Accent Vision Care

PATIENT NAME & DOB (please print)_____

HIPAA CONSENT

Our notice of Privacy Practices provides information about how we may use and disclose protected Health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice (copy available upon request) before signing this consent. You have the right to revoke this Consent. The practice provides this form to comply with the Health insurance Portability Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

I hereby acknowledge that I can receive a copy of the Medical Practice's Notice of Privacy Practices upon request.

Responsible Party signature_____ Date _____

CONSENT FOR TREATMENT

I hereby authorize Accent Optical Inc, DBA Accent Vision Care physicians, together with associates and assistants of his/her choice, to administer or perform a medical/vision exam, any diagnostic testing and medical treatment, procedures, therapy, and any additional procedures/services as they may deem necessary or reasonable, including the administrations of any general or regional anesthetic agent, and I hereby Consent thereto.

Responsible Party signature_____ Date _____

I give my permission to the following person(s) listed below to authorize any medical treatment and discuss the patient's medical records:

Name:	**Date of Birth:**	**Relationship:**
_____	_____ /_____ /_____	_____
_____	_____ /_____ /_____	_____

FINANCIAL RESPONSIBILITY & INSURANCE SIGNATURE ON FILE

- We will gladly file your insurance; however, you will be responsible for any charges your insurance company does not pay. If your insurance company pays after you have paid, we will reimburse you.
- Please be aware that many insurance plans require that you see an "in network" provider. Many plans also have restrictions on how often they will pay, I.e., one exam 12 months from the last date of service. Please also be aware that insurance benefits are sometimes misquoted by customer service representatives, and we can only go by the information we are given. We will verify your insurance coverage whenever possible; however, you are ultimately responsible for knowing your insurance coverage and eligibility.
- We are required to accept certain allowances with the insurance companies with which we are contracted; however, we are not required to accept all allowances of other insurance companies with which we are not contracted, you will be responsible for paying the amount your insurance company does not pay.

I have read the above insurance policies of Accent optical Inc, DBA Accent Vision Care, and I agree to pay any charges that my insurance company does not pay. I understand that some services may not be covered, as dictated by my insurance company. If my insurance company denies the claim as non-covered service, I understand that I will be responsible for the balance. If my account becomes delinquent, I agree to pay all collection costs, including any attorney fees.

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Accent Optical Inc, DBA Accent Vision Care to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Accent Optical Inc, DBA Accent Vision Care, on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release HCFA any information needed to determine these benefits payable to related services. If I have other Health insurance coverage, my signature authorizes the release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Responsible Party signature_____ Date _____

Print name_____ Relationship (if other than patient) _____