## Riddle Eye Associates Office Policies 610-565-6780

**INSURANCE INFORMATION**
**1**. INSURANCE IDENTIFICATION AND YOUR DRIVERS LICENSE must be presented BEFORE the examination.
**2.** PRIOR AUTHORIZATION from your insurance company is required before services are rendered.
3. Your claim cannot be processed without VERIFICATION of ELIGIBILITY by our office PRIOR to your exam.
**4.** Please understand that YOU are financially responsible for all services not covered by your insurance company.
**5.** We ask that you be prepared to pay your portion of the exam (co-pay) at the time services are rendered.

**APPOINTMENT POLICY**
There may be a $20.00 fee charged to patients who do not give 24 hours notice for cancellations and/or miss their appointments.

**OUR PAYMENT POLICY**
- Fees are due at the time services are rendered.
- A $25.00 administrative fee will be charged on ALL returned checks. Exam and/or Contact Lens Fees are **NOT** refundable.

**OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS (HIPAA)**
Our office is committed to compliance with the HIPAA guidelines by:
1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's information.
3. Providing our patients with proper access to their records.
4. Appropriately maintaining our patient information and billing processes in compliance with national
5. HIPAA standards.
Complete HIPAA compliance will be furnished upon request. If you ever have any questions or concerns about your services or charges, we encourage you to call and ask our Office Manager.

**Signature Authorization (please initial each statement after reading)**
_____I understand my health insurance carrier will be billed if my routine vision exam becomes medical in nature, and I understand I will be responsible for any applicable co-pays, deductibles, etc.

_____I acknowledge that I have read and fully understand Riddle Eye Associates Patient Policies, (the information listed above regarding appointments, insurance and payment policies), and conditions thereof. I also understand I am financially responsible for any service not covered by my insurance plan, and that payment for non-covered services is expected at the time of service. I understand that if any unpaid balance on my account is sent to a collection agency, I will be responsible for all fees associated with collection of the debt.

____I acknowledge that all information in my medical record is confidential and may be handled by the support personnel of Riddle Eye Associates and their employees.

_____I authorize the release of my medical information to the third party organization that is necessary to process claims for services rendered.

_____I authorize the payment of my medical/vision insurance benefits to Riddle Eye Associates or to any party who accepts assignment for all services provided.

_____I have received a copy of the HIPAA Notice of Privacy Practices.

**Patient Signature** _____**Date**_____

**Parent/Guardian Signature** _____**Date**_____