NOTICE OF PRIVACY PRACTICES

HIPAA Omnibus Act
September 2013

SUMMIT EYE CLINIC, S.C.
608 East Summit Avenue
Oconomowoc, WI 53066
Telephone: (262) 567-6565
Fax: (262) 567-8214

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- > **Treatment, payment and health care operations**
- > **Uses and disclosures for other reason without permission**
- > **Your rights regarding your health information**
- > **Complaints**
- > **Appointment reminders**
- > **Other uses and disclosures**
- > **Our notice of privacy practices**
- > **For more information**

I acknowledge that Summit Eye Clinic has HIPAA Privacy Practices And that I have a right to read and receive a copy of those practices if I so request.

Patient Name (please print)	Signature of Patient or Legal Guardian	Date

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FINANCIAL POLICIES

☐ **PATIENTS OF CONTRACTED MANAGED CARE PLANS / SECONDARY INSURANCE:**
If our office is contracted with your health plan, we will submit your claim to the carrier. **You are expected to pay your co-pay at the time of service**, per your contractual agreement with your insurance carrier. All Insurance cards, both primary and secondary or supplemental, need to be presented at time of service. We choose the right to submit to insurances that are presented at the time of service; submittals after the day of service are the patient's responsibility.

You are responsible for all services provided by our office which are not covered by your insurance. Please contact your insurance company in advance to verify coverage for benefits such as refractions, contact lens exams, routine eye care, and any deductibles that may apply.

☐ **PATIENTS WITH PRIVATE HEALTH INSURANCE PLANS WITHOUT SECONDARY INS:**
You are responsible for your portion at the time of service. As a courtesy, and upon request, we will file your insurance claims providing your portion of the payment is made in full at the time of service. Refraction/check for glasses is not a covered benefit under most insurance. The refraction charge is $32.00; you are responsible for the payment of this at the time of service.

☐ **PATIENTS WITH NO INSURANCE BENEFITS:**
You are responsible for payment in full at the time of service.

☐ **ALL PATIENTS OF OUR PRACTICE:**
Please bring your insurance cards with you and keep our office informed of any changes in your insurance, address, telephone numbers, and employment. For your convenience we accept Debit Cards, MasterCard, Visa, Discover, American Express, Checks, Cash, and CareCredit.

☐ **DELINQUENT ACCOUNTS:**
Accounts greater than 90 days past due are subject to collections.

☐ **PATIENT APPOINTMENTS:**
Canceling or rescheduling an appointment with less than 24 hour notice, may result in a FEE.

☐ **ACCEPTANCE:**
I have read and understand the financial policy and agree to abide by the terms of this policy.

Patient Name (please print)	Signature of Patient or Legal Guardian	Date
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