AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Act of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/medical information on voicemail at these phone numbers?

❑Yes ❑No Home phone:_____ ❑Yes ❑No Cell Phone: _____

May we contact you at your place of employment? ❑Yes ❑No

If yes: Work Phone: _____ May we leave a message? ❑Yes ❑No

Do you have any **person or family members** that you **authorize** to receive and discuss information regarding your **personal health information** (general information, surgical, and billing)? ❑Yes ❑No If yes, please provide names:

Name:_____ relationship:_____ Phone:_____
Name:_____ relationship:_____ Phone:_____
Name:_____ relationship:_____ Phone:_____
Name:_____ relationship:_____ Phone:_____

Is there a person who has Power of Attorney for Medical purposes? ❑Yes ❑No

Name:_____ relationship:_____ Phone:_____

If the patient is a **minor**, kindly print parent(s) and/or guardian name(s) that are entitled to receive medical records or information

Name:_____ relationship: _____phone: _____

I hereby authorize_____ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, labs, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above. I have reviewed **Draga Eye Care Notice of HIPAA Privacy Policy.** A Copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date:**_____

Witnessed by: _____

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NOTICE OF INSURANCE WAIVER

PATIENT NAME:_____

Many insurance companies charge an additional co-payment, co-insurance, and/or deductible for procedures performed in the office. Because we are a specialist's office many patients will have diagnostic procedures and tests along with their office visit.

We may not be aware if your insurance plan mandates that you are responsible for additional copays for necessary testing or procedures, this is determined when we submit your claim to your insurance company. We will accept your co-payment at the time of service. Should you receive a bill for an additional amount it is based on the determination of your insurance plan.

Draga Eye Care will submit the claim on your behalf and you will be billed based upon the explanation of benefit notice we receive from you insurance plan.

Additionally, there are services provided which are not covered at all by your insurance plan, payment for these services is due at the time of service.

Thank you for your understanding and cooperation.

Draga Eye Care Billing Office

_____ _____

Patient Signature of Agreement **Date**

Revised 11/2014