Nicolitz Eye Consultants

Authorization to Discuss Medical Information

Name: _ DOB:_ _ _ _ _ _ _ _ _ _ _

In accordance with the Health Information Portability and Accountability Act (HIPPA), clinical information cannot be discussed with spouses, family members or friends without written authorization. I **authorize the following person(s) to obtain clinical information on my behalf.**

_____ _____

_____ _____

_____ _____

_____ _____

This authorization may be amended at my discretion with written directive from me.

_____
Signature

PHOTOGRAPH AND VIDEO RELEASE FORM

Nicolitz Eye Consultants collects and uses photographs and videos of various procedures and conditions to use in public service endeavors, educational and charitable programs, and teaching program materials. By signing the release below, you are agreeing to allow photographs or videos of yourself, and your medical history connected to the material, to be used by Nicolitz Eye Consultants **If your picture has been taken in reference to a particular medical condition, your name will not be used in connection with the photographs or medical information.**

DO or DO NOT GIVE MY PERMISSION, without restriction, for consideration received, for Nicolitz Eye Consultants to take, reproduce and publish, in all media including electronic formats known or unknown, photographs or videos of me, or to have this done on their behalf. I understand that these photographs or videos may be used, in whole or in part, in informational, educational or commercial publications of any kind (including without limitation, electronic publishing), by Nicolitz Eye Consultants or their affiliated corporations I understand that although the materials will not contain my name or any other identifying information, I may or may not be identified by the photos.

If selecting "DO" above, I agree that this also grants my permission to use in connection with the photographs or videos, for any purposes whatsoever , all or any portion of any writing, summary, description or synopsis setting forth my medical diagnosis, treatment and results, and also give my permission for my physician to release medical information about my diagnosis, treatment or results in connection with the photographs. I understand my name will not be used in connection with medical information or photographs.

I UNDERSTAND AND AGREE THAT:

1. I will not have any right to inspect the finished work or product or to approve its use.
2. The originals and all copies of the photographs, videos, and negatives and any copyright rights in them will be owned by Nicolitz Eye Consultants, and it will have all rights to use, not use or dispose of the photographs or videos, in any manner whatsoever.
3. I will not retain any rights of privacy or publicity or any other rights I may have in the use of my photographs or videos.
4. The agreements in this Release are binding and cannot be changed by me or someone who has been given my rights.

PLEASE TURN OVER AND SIGN

Nicolitz Eye Consultants

BILLING [POLICY

PLEASE NOTIFY US OF **ALL** YOUR CURRENT MEDICAL INSURANCE PLANS AT EACH VISIT.

MEDICARE

1. We file and accept Medicare assignment.
2. As a courtesy to our patients we will file your secondary insurance, if not filed by Medicare through Medigap.
3.

HMO PATIENTS

1. Please ensure you have a current referral on file with us
2. A current referral is needed for every visit and to schedule surgery.
3. It is solely the patient's responsibility to secure this referral from the primary care physician.
4. Without a current referral, it will be necessary to reschedule your appointment.
5.

ALL INSURANCE

1. Please check if we participate in your health care plan and present your current insurance card.
2. Co-pay/ Coinsurance / and Deductibles are due at the time service is rendered. **We accept cash, checks, VISA, MasterCard, Discover and American Express.**
3. If your insurance has not paid within 35 days, you are responsible for your bill.
4. Once your insurance has paid, you will be billed for the balance due.
5. Only three (3) requests for payment will be sent, after which your account will automatically be referred to an outside collection firm.
6. **PLEASE NOTE: You will be responsible for all late fees and collection costs assessed by the collection firm.**
7. There is a $40.00 charge for all returned checks. Paid by CASH or MONEY ORDER ONLY.
8. There is a minimum charge of $20.00 to fill out disability or other forms. There is a 14 BUSINESS DAY MINIMUM tum around time.
9. There will be a reproduction fee of $1.00 per page for the first 25 pages and $0.25 for each additional page, plus postage, PREPAID, for copying all medical records.
10. **There is a $40 refraction fee (glasses exam) and $85 Prism refraction fee are not covered by insurance payable at time of refraction exam. Initial if you have received the refraction form**
11. **There will be a $30 NO SHOW fee for any missed pre-surgical testing appoints. This is not paid by your insurance company. This will be your responsibility to pay.**
12. **There will be a $20 NO SHOW fee for any patient who fails to show for a scheduled appointment without contacting the practice to cancel the appointment within 24 HOURS prior to the scheduled appointment.**
13. **There will be a $75 surgical fee for all in-office surgeries payable on the day of surgery. This is to cover the cost of the surgical supplies and it is not covered by your insurance.**

I have read and understood the billing policy, authorization to discuss medical information and photograph and video release form.

ADULTS:
Signature:_____ **Date:**___

Printed Name:_____
FOR MINORS:
Signature:_____ **Date:**___

Printed Name:_____

Status: Parent:___ **Guardian:**___

Name of Nicolitz Eye Consultants' Physician, Employee, Author, or Staff Person Who Obtained Paperwork:
Signature:

Printed Name:

Date: