NOTICE OF PRIVACY AND FINANCIAL POLICIES

Financial Policies:

- I understand that I am financially responsible to Eye Care Associates of Owosso, P.C. (ECAO) for any and all insurance deductibles, copayments, or any services or materials determined as a non-covered benefit by my insurance carrier.
- I understand that in cases where divorced or separated parents have shared responsibility of care for dependent children, the parent bringing the minor to our office is responsible for deductibles, copayments, or non-covered services at the time of the appointment.
- I authorize ECAO to release any information including diagnoses, treatments, and examinations rendered to me or my dependents to third party payers and/or health providers.
- I authorize my vision or medical insurance carriers to pay directly to the eye doctor or ECAO.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.

- I understand that routine vision exams will be billed to my vision insurance if one is available and we participate with it. Routine vision exams require a routine vision diagnosis (i.e. near-sightedness, far-sightedness, astigmatism, etc).
- I understand that if a medical diagnosis is determined by the doctor, my exam would then be considered medical and be billed to my medical insurance. (This is the reason we request your medical insurance card.)
- If I have no vision insurance, I understand that I am responsible for payment of the exam at the time of service.

HIPAA Privacy Policy and Authorization for disclosure of Protected Health Information:

- I acknowledge that I received/reviewed a copy of Eye Care Associates of Owosso, PC's Notice of Privacy Practices.
- I authorize doctors and staff to disclose information about my medical and financial conditions with the following friends and/or family:

Name & Relation_____ Name & Relation_____

Name & Relation_____ Name & Relation_____

I have read and understand all of the above information.

_____ _____ _____

Signature of patient or guarantor | Relationship if not patient | Date

_____

Printed name of patient

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