Notice of Privacy and Financial Policies

Patient name: _____ Date:_____

Financial and Insurance Authorization: PLEASE READ & SIGN BELOW

I authorize *West Michigan Eyecare Associates* to release any information including diagnosis, records of treatment or examinations rendered to me or my children during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or group insurance benefits otherwise payable to me. I understand my insurance may pay less than the actual billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

WMEA is committed to caring for our patient's complete ocular health. Our patients will receive a **Complete Eye Health Examination.** Our doctors are trained to diagnose and treat ocular diseases. As a courtesy to our patients, we are happy to file with your insurance company. Note: the patient is responsible for any copays/deductibles which insurance requires at time of service.

Routine Vision Exams will be filed with a patient's vision plan if one is available and we participate. A routine exam means there is not a medical diagnosis. Routine diagnoses include myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, and presbyopia. If a **Medical Diagnosis** (cataracts, glaucoma suspect, foreign body, diabetes, dry eye, etc) is determined by the doctor, the patient's exam is no longer routine, but medical. This means we will bill your medical health plan. We request a copy of your medical card in your chart for these reasons.

WMEA takes pride in providing the best care and products for our patients. We will strive to resolve all your eyecare and optical needs. Any product returns are for in office credit and prescription rechecks may be subject to additional charges.

Privacy Policy and Authorization of Use and Disclosure of Protected Health Information

I acknowledge that I have received/reviewed a copy of *West Michigan Eyecare Associates* Notice of Privacy Practices. I know that at anytime I can request my own personal copy of the form. I authorize doctors and staff to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals:

(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