

Notice of Privacy Practices /Dr. Jackman, OD

- ____ * I was given the opportunity to read the Notice of Privacy Practices, for M.D. Jackman,OD and I wish to continue my care with Dr. Jackman under the terms of his privacy practices.
- ____ * I have read the Notice of Privacy Practices for Dr. Jackman,OD and do not wish to continue my care with Dr. Jackman under said terms.
- ____ * The Notice of Privacy Practices could not be read due to the emergent nature of the care or reason described below: _____
- * ___ I (do) ___ (do not) authorize Dr. Jackman OD or his staff to leave a message with available persons, on my answering machine at my home phone number or with emergency contact listed.
- * ___ I (do) ___ (do not) authorize Dr. Jackman or his staff to leave a message at my place of employment.

I hereby authorize Dr. M.D. Jackman, OD to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of protected health information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & I am signing this form voluntarily.

Patient or Legal Guardian's Signature

Date

FINANCIAL & INSURANCE FILING POLICY:

All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Insurance confirmation/authorization is not a guarantee that all services will be covered. We cannot become involved in disputes between you & your insurer.

If your insurance company does not pay within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company does not pay within 45 days, we will require you to pay the balance. **Cancelled or rescheduled appointments are subject to a fee if we do not receive a 24 hour advance notice.** _____ Initials

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS:

_____ does authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Dr. M.D. Jackman, OD. I also request that payment of authorized Medicare(if applicable) benefits be made on my behalf to Dr. Jackman for any service performed. I authorize any holder of medical information necessary related to me to be released. I understand that my signature requests that payment be made & authorizes release of medical necessary information to the insurer or agency shown. The supplier agrees to accept the charge determination of the Medicare carrier & the patient is responsible for the deductible, co-pay & any non-covered services. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is considered as valid as the original. I request that you file my insurance. I accept financial responsibility for all charges. I have read & understood all this information and I am signing voluntarily.

Patient or Legal Guardian's Signature

Date