

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Text Message |
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Email |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> All Phone | |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Text Message |
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Email |
| <input type="checkbox"/> Work Phone | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- | | |
|--|-------|
| It was emergency treatment | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign | _____ |
| The patient was unable to sign because | _____ |
| Other (please describe) | _____ |

Signature of Privacy Officer

FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. Your clear understanding of our Financial Policy is important to our professional relationship. Our front desk receptionist and billing staff will be happy to assist in answering any further questions you may have. A copy will be provided to you upon request.

Insurance. We participate with Medicare, Blue Cross Blue Shield and several commercial insurance companies. You must provide our office with the necessary billing information for the visit, we will submit the charge on your behalf to your insurance. **You will be asked to provide us with your insurance card(s) at each visit.** Payment of all non-covered services and supplies will be requested at your service visit. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.

Guarantee of Payment. All copays, coinsurance and deductible must be paid at the time of service. I hereby guarantee payment of all charges not paid by insurance, together with all necessary collection expenses. I understand that all bills are payable and become due upon presentation.

Nonpayment. A statement fee of **\$3.00 or 1%** of the outstanding balance, whichever is higher, will be charged for all billing statements issued on accounts with balances over 60 days past due. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. **Partial payments will not be accepted unless otherwise negotiated.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Returned Check and Credit Card Dispute. A **\$27** charge will be applied to all returned checks and credit card disputes.

Missed appointments. Appointments that are not canceled at least **48 hrs.** prior to the appointment will be considered a no show. Our office does not charge for missed appointments, however **two no show** appointments in a 12 month period would result in loss of appointment scheduling privilege, and could result in discharge from the practice. Please help us to serve you better by keeping your regularly scheduled appointment.

INSURANCE PATIENTS I hereby authorize *Thao Nguyen Tran MD SC* and its employees to release any/all medical information necessary to process claim(s) to my insurance carrier(s). I irrevocably authorize the insurance carrier(s) to assign all benefits/payments directly to *Thao Nguyen Tran MD SC*. I understand that I am financially responsible for all charges whether or not my insurance covers those charges.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to the provider. I further hereby authorize Medicare or their contracted carrier to furnish to *Thao Nguyen Tran MD SC* providers of service any information regarding my Medicare claims under Title XVII of the Social Security Act.

By signing below, I acknowledge that I have read and agreed to this Financial Policy.

Patient or Personal Representative Signature

Date

RECORDS RELEASE

Notice of Privacy Practices. The Notice of Privacy Practices explains how *Thao Nguyen Tran MD SC* may use and disclose your health information. By signing below, I acknowledge receipt of the Notice of Privacy Practices of *Thao Nguyen Tran MD SC*

Prescription History Consent. By signing below, I give *Thao Nguyen Tran MD SC* permission to access a two year history of my medications for my care and treatment.

Patient or Personal Representative Signature

Date

Name of Personal Representative (PLEASE PRINT)

Relationship

Payment Policy

Thank you for choosing us for your eye care. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Definition: For the health care service reimbursement, your insurance plan defines the **allowed amount** that must be collected by our office at the time of service. Whenever possible, this amount is verified at the insurance websites before your appointment. You can request a copy of this information with the staff. **Copay** is the fixed amount you pay for the service. **Annual Deductible** is the amount you pay **before** your health insurance begins to pay. **Coinsurance** is the fixed percentage of the cost that you pay **after** the deductible is met. **Non-covered services** are out-of-pocket expenses to you as the insurance company will not pay for these expenses. The typical non-covered service is the refraction which will be clarified in the Section "Refraction Out-of-pocket Expense".

2. Patient Financial Responsibilities. The service fee is defined by the insurance carrier contract with the doctor. Your financial responsibility is determined by the insurance plan that you have with the insurance company. Whenever possible, we will share the information that the insurance carrier has provided to us, you will need to contact the insurance company to fix any discrepancies between this information and your understanding of your benefit. We are required by law to collect the reimbursement based on the provided information from the insurance carrier. The information on your cards is used to verify your eligibility and benefit at your insurance website. Without this information, we must assume that there is no insurance coverage and collect payment accordingly.

3. Overpayment. Whenever possible, we verify your patient responsibilities at the insurance website to calculate the payment collection at check-in. Should this information not be up-to-date and your insurance plan determine that your responsibilities is less, we will notify you that a payment is coming via text messaging or phone call and mail the **refund** check to the address on file. Please review with staff the contact information on file: name on the refund check, mailing address, cell phone for text message and landline phone for voicemail. Any incorrect contact information can cause a delay in the refund process.

4. "Medical" and "Vision" Insurance. Vision plan such as VSP is intended to provide patient with a baseline eye evaluation and update your glasses prescription only. If the doctor discovers a medical eye condition during a routine exam, the doctor will inform you that your visit is now a medical exam and your claim will be coordinated between your medical insurance as primary and the "vision" insurance as secondary to minimize your out-of-pocket expense. The copays, deductibles, and coinsurances of the medical Insurance will be applied and collected at the visit. The typical medical eye conditions are but not limited to: cataracts; macular degeneration; glaucoma; dry eyes; cornea problems. You also have the option to finish the routine examination and return at a later date for the medical exam. However, this option will not have the coordination of benefit between the 2 plans and your out-of-pocket expense can be higher.

5. Refraction Out-of-pocket Expense. Refraction service is the part of the exam by which we determine whether you need a new eye glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for the doctor to assess your eyes to look for problems. Since Medicare and most medical insurance plan

treat this service separate from the eye exam and do **NOT** cover this “vision” service, we collect **\$26.00** at check-in (**\$36 if bill**). Should your plan pay us for the refraction, we will reimburse you accordingly.

6. Payments at Time of Service and Billing. During check-in, you will be asked to pay the patient financial responsibility for the office visit, planned office procedures, and non-covered services such as refraction. Patient financial responsibilities for additional office procedures will be collected at check-out. After the claim is paid, we will send you a statement for outstanding charges to your home address on file. Your insurance plan will determine your patient financial responsibilities and office responsibilities as explained below:

If You Have ...	Patient Financial Responsibilities	Office Responsibilities
Commercial Plans in which we have a contract.	<p><u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are requested at the time of the office visit.</p> <p><u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of the visit.</p>	<p>We will verify your benefit online and collect based on the information provided by your insurance company.</p> <p>We will file claim on your behalf</p>
Commercial Plans with which we are <u>not contracted</u>	Payment in full for office visit and office procedures at the time of the office visit	<p>We will verify your benefit online and collect based on the information provided by your insurance company.</p> <p>We will file claim on your behalf</p>
Medicare Medicare Advantage Medicare HMO	<p><u>Remained annual deductible</u> will be collected at the time of visit unless we can verify that the secondary insurance or Medigap has this coverage benefit.</p> <p><u>20% Medicare Copay</u> will be collected if you have no secondary or Medigap coverage.</p> <p><u>Non-covered services</u> are collected at the time of the visit.</p>	<p>We will verify your benefit online and collect based on the information provided by your insurance company.</p> <p>We will file claim on your behalf</p>
Worker’s Compensation	<p><u>If we can verify the claim with your carrier:</u> No payment is necessary at the time of the visit.</p> <p><u>If we are not able to verify your claim:</u> Payment in full is collected at the time of the visit.</p>	<p>We will call your carrier to verify the accident date, claim number, primary care physician, employer information and referral procedures</p> <p>We will file claim on your behalf</p>
Worker’s Compensation (Out of State)	Payment in full is collected at the time of the visit.	We will provide you a receipt so you can file the claim with your carrier
Occupational Injury	Payment in full is collected at the time of the visit.	We will provide you a receipt so you can file the claim with your carrier
Travel Insurance or Unfamiliar Insurance	Payment in full is collected at the time of the visit.	We will provide you a receipt so you can file the claim with your carrier
No Insurance	Payment in full at the time of the visit.	<p>We will work with you to settle your account.</p> <p>Please ask to speak with our staff if you need assistance.</p>

7. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

8. Proof of insurance. All patients must complete our patient information form during the first visit and update the form on an annual basis. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

9. Referral. If your insurance plan requires a referral, you are responsible to request your primary care physician (PCP) to submit an **electronic** referral with the insurance company before your appointment. Most commercial HMO, Medicaid HMO and Medicare Advantage plans are no longer accepting paper referral. If the referral is not available at the time of service, you must pay for the services in full at the time of visit as the insurance company may deny your claim for missing prior authorization. You can also reschedule the appointment and wait until the referral is logged into the insurance database.

10. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

11. Insurance Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

12. Late payment. In the event payments are not received within 30 days of the statement date, an administrative fee of **\$2 or 1%** of the outstanding balance, whichever is higher, will be added to your account on a monthly basis until a payment plan is negotiated or the balance is paid in full. Please contact the office to discuss payment.

13. Payment Plan. In case you need some payment assistance, please contact our office to complete a payment installment form. This form must be received together with the first installed payment.

14. Nonpayment. If your account is over 90 days past due, we may refer your account to a collection agency. Any legal fees associated with those collections will be your full responsibility. If a **check is returned** for non-payment, you will be charged a \$27 fee for related expenses per occurrence. If a **credit card payment is denied**, you will be charged a \$27 fee for related expenses per occurrence.

15. Late Arrivals. We cannot hold the appointment after 10 minutes of your appointment. Every effort will be made to serve your needs, as time allows and being respectful of previously-scheduled appointments. You have the option to wait or to reschedule to a time that is more convenient for you. **Two** rescheduled appointments due to late-arrival within 12 months will result in loss of appointment scheduling privilege and could result in discharge from the practice.

16. Missed appointments. All patients have the opportunity to miss **one** scheduled appointment in a 12 month period. After 2 late-cancel/failed appointments within 12 months, you can only reserve appointment on the **same day of service**. An appointment cancelled within 48 hours of the appointment is considered a late-cancel appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

17. Contact Methods. For schedule reminder and payment notification, we will contact you via phone, text message, email, and postal mail to the contact information associated with your account.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient or Guardian Name

Patient/Guardian Signature

Date

Relationship if not signed by patient