Financial Responsibility

Payment is due when services are rendered. However, with insurance uncertainties, we cannot always accurately estimate what, if any, financial responsibility your visit will generate. We will gladly file your insurance as a courtesy, but you, or your designate, will still be financially liable for these charges should your insurance company not pay or pay less than expected. This may be due to co-pays, co-insurance, deductibles, or denial.

Please present ALL insurance cards you may have to reduce this uncertainty.

Please indicate who will be financially responsible for your account and **complete in its entirety**:

Name: _____ Date of Birth:_____

Address: _____ Phone: (____)_____

City/St/Zip: _____ Relationship to Patient:_____

Insurance Release

Please sign regardless of insured status in the event you become insured in the future

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Brady M. Palmer, OD** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____

Signature Date

Patient Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPPA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies, and others put in place controls to ensure that your medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physicians, your hospital, and your insurance company. We will not share your information unless it is needed by your PCP, or if we need to refer you for further treatment. By signing this consent form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You are also consenting to have an exam and receive treatment. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may disclose protected health information about you. You have the right to this notice before signing this consent.

Signature of Patient (or Parent/Guardian): _____ Date: _____

Permission To Share Protected Health Information

If you fail to complete this section, or choose not to complete it, we will be unable to discuss personal medical information with anyone other than the named patient.

Federal law says that our office cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information that we have with the person/people you indicate below.

- This authorization is voluntary.
- Right to revoke : If you decide you do not want us to share your health information any longer, contact our office and we will provide you with the proper forms.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- We cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact our office to get a copy if you do not have one.

Patient name:_____ Date of Birth ____/____/_____

I give permission for Dr. Brady Palmer and/or his office designate to discuss my personal medical information to the following individuals:

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

Patient (or Guardian) Signature:_____ Date: _____