FOX OPHTHALMOLOGY ASSOCIATES

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ADVANCE NOTICE & ACKNOWLEDGEMENT OF POLICIES

HIPAA PRIVACY POLICY A copy of our Notice of Privacy Practices is posted at the front desk. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

ASSIGNMENT OF BENEFITS Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to Fox Ophthalmology Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from Fox Ophthalmology Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred during the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

Patient Signature: _____

Patient Name (print): _____

Date:_____