Eye Care Center of Rome
1320 Floyd Ave
Rome, NY 13440
315-337-3277

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Patient Address: _____

I authorize the professional office of my doctor, to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. **Detailed description of the information to be released:**

   □ **Billing and Medical Purposes only**

   □ **Name of other party to be given access to your information** _____

2. In order to bill your insurance or share medical information for any referrals that we may make on your behalf we need your written permission, by signing below you are giving us that authority. Without this signature we can not bill your insurance for you and you would be responsible for all fees accrued during this visit

3. Expiration date or event relating to the individual or purpose for the release:
It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.
When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.
If you are authorizing us to use your health information for marketing activities, please be advised that we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.
I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____**Date**_____
If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to Patient _____

Print Name _____

Source of Authority _____

EYE CARE CENTER OF ROME FINANCIAL POLICY

Thank you for choosing The Eye Care Center of Rome for your optical care. We are committed to building a successful physician patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship.
Please understand that payment for services is a part of that relationship.
Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc).

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of checkout unless previous arrangements have been made with our billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.
All returned checks will have a processing fee of $35 added to your balance.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in the patient being responsible for the entire bill.
Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits, therefore any fees not paid by your insurance company are ultimately your responsibility.

Referrals and Preauthorization's
Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist.
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it.
Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account a single phone call will be made to try to make payment arrangements.
If no resolution can be made, the account will be sent to a collection agency.

No Show Policy
We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time. If you no show for any appointment with us a $25 fee will be charged to your account.

Refunds
Orders for Glasses: Orders for glasses are custom made according to your prescription as determined by your exam. Before ordering your glasses a 50% deposit is required before starting order. All glasses must be paid for in full at dispensing. If you are having issues with your new glasses our office will work with the patient to get the issue sorted.
There are absolutely no refunds on glasses.

_____ _____
Signature of patient/responsible party **Date**

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us. On 315-337-3277.