Pinnacle Eye Group

Financial Information and HIPAA Notification

Financial Responsibility:

I understand that payment in full is due at time of service unless other arrangements have been made and that my insurance carrier may pay less or none of the actual bill for products and services. I agree to be responsible for payment of all products and/or services rendered on my behalf or the behalf of my dependents.

Authorization and Release:

I authorize the release of any information including the diagnosis and records of treatment or examination rendered to me or my child to third party payers and/or other health care providers.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

Name of Patient: _____DOB_____

Name of Insured: _____DOB_____

Name of Insurance Carrier: _____

Insurance ID#_____ Policy/Group#_____ Card Copied Y___ N___

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to our contact person, Amy Hinckley at ahinckley@pinnacleeyegroup.com or 3723 King Rd. Suite 100 Toledo, OH 43617. If you prefer, you can discuss your complaint in person or by phone at 419-843-2020 or fax 419-843-8733.

Changes to this notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised notice that will be posted prominently in our facility. Copies of this notice are also available upon request at our reception area.

Notice Revised and Effective: October 1, 2018

ACKNOWLEDGEMENT OF RECEIPT

I_____, acknowledge that I received or was offered a copy of Pinnacle Eye Group's Notice of Privacy Practices.

Patient Name_____

Signature_____Date_____

Pinnacle Eye Group Contact Authorization

Due to government regulations concerning healthcare and patient privacy, we need your permission to leave messages on your voicemail or answering machine. We also need your approval to speak to anyone about your healthcare information. By signing below you agree to allow us to leave messages on an answering device and to speak to anyone you have named in the spaces provided below.

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

I agree to allow Pinnacle Eye Group to leave messages on an answering device and to speak to the above named people about my vision, health and prescriptions.

Printed Name Date

Signature