NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have viewed or have been given a copy of Troy L. Bedinghaus, O.D., P.A.'s Notice of Privacy Practices. A copy of our Notice of Privacy Practices is posted in the reception/waiting area of our office.

NO SHOW FEE: Please give us 24 hours advance notice if you cannot make your appointment. A No-Show fee will be charged if you do not make your appointment and fail to give us advanced notice.

PAYMENT POLICY: Third party insurance information must be given at least 24 hours in advance so that we may obtain prior authorization and verification of benefits or you will be considered self-pay. Payment is due the date when services are rendered. If we are billing insurance, you will be responsible for your **co-pays, refraction, co-insurance and or deductibles**. You will be responsible for the remainder of your examination if your insurance does not pay within **45 days.**

Patient or Patient representative _________________________________ Date _______________

SIGN BELOW IF WE ARE BILLING INSURANCE ON YOUR BEHALF

We are a provider for most medical insurance and many vision plans**.** ***If you are coming in to have a medical complaint, problem or condition addressed, we are required to bill your medical insurance for your eye exam. Most often, we can still check your vision and measure for glasses even though we are evaluating a medical problem. If you are coming in for a routine vision exam to have your glasses or contact lenses updated, we will bill your vision plan****.* By signing below, you give us permission to bill your **medical plan** or **vision plan** depending on the **reason for the visit**.

I hereby authorize the physician to release any information required to process this claim. If the physician is accepting insurance, I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions.

Patient or Patient representative ________________________________ Date ________________

SIGN BELOW IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH INSURANCE

I request that payment of authorized Medicare benefits be made to Troy L. Bedinghaus, O.D., P.A. for services rendered to me by him. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits. I understand my signature request that payment be made and authorizes release of medical information necessary to pay this claim. If other health insurance is listed in item 9 of the CMS 1500 or elsewhere, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Troy L. Bedinghaus, O.D., P.A. agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ________________________________ Date ______________