Simpson Optical

340 Meijer Way, Lexington, KY 40503
859-278-2020, Fax: 859-277-4490
4101 Tates Creek Centre, Lexington, KY 40517
859-245-3332, Fax: 859-245-0032
989 Governors Lane, Ste 180, Lexington, KY 40513
859-554-8265, Fax: 859-309-9032
www.simpsonopticalky.com

Authorization to Pay Benefits and Release Information

I hereby authorize the release of any medical or personal information necessary to process this and all future claims, and request that payments of assigned benefits be paid to Simpson Optical.

I also authorize Simpson Optical to deposit checks received on my account when made out to my name. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I further agree to pay any amounts due for deductibles, co-insurance or non-covered services.

I authorize Simpson Optical to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this Assignment shall be considered as effective and valid as the original and shall remain in effect until I withdraw or change this consent by notifying Simpson Optical in writing.

_____ _____ _____

Signature of Patient/Insured or Parent/Guardian Date Witness

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Patient's Financial Responsibility

Descriptions and verification of benefits and eligibility by an insurance company are not a guarantee of payment. I understand that I am responsible for any amount not covered by my insurance.

I understand that Simpson Optical is filing my insurance as a courtesy and that the description of benefits and eligibility given to them by my insurance company is **NOT A GUARANTEE OF PAYMENT**. If for any reason, my claim is denied, I am responsible for payment of all charges to Simpson Optical for professional, medical and materials charges immediately upon request.

I further acknowledge that I am responsible for all co-pays, deductibles, coinsurance and additional charges over and above my insurance for this, and all future visits.

I agree to provide all current insurance information and cards at each visit and understand that if this information is incorrect or not presented by me at my visit, it will be my responsibility to pay for all charges in full, at the time of service, and I will be responsible for filing my claim. I understand by doing so, this claim may be paid as 'out of network benefits' by my insurance company and Simpson Optical will not reimburse me for any amounts paid over what my insurance company pays.

Simpson Optical's Payment/Return Policies are as follows:

- **We require payment in full at the time of service**. We accept all major credit/debit cards, cash or check as payment.
- We charge a service fee of $5 per month for all unpaid balances over 30 days old. We charge $20 for all returned checks. Patient/customer is responsible for all court costs, attorney/collections fees incurred to collect any outstanding balances. Simpson Optical may release my personal, billing and any other information needed in collection of my debt.
- There is no refund on any exam services/tests provided by our staff.
- 70% refund on all patient paid portions of glasses and contact lenses within 30 days of purchase. Glasses must be in the same condition as sold. Contacts must be in unopened, unmarked boxes.
- Readers are non-refundable but are exchangeable for another power or in-store credit within 30 days of purchase provided they are in the same condition as sold.

By signing below, I am indicating that I have read, fully understand and agree to abide by these policies.

_____ _____ _____

Signature of Patient/Insured or Parent/Guardian Date Witness

HIPAA – Health Insurance Portability and Accountability Act

Simpson Optical complies with all HIPAA regulations – your medical and personal information is confidential. A copy of the complete privacy policy is available at the front desk. By signing below, I acknowledge that a copy of the HIPAA policy has been made available to me.

_____ _____

Signature of Patient/Insured or Parent/Guardian Date

Non-Insured Patients

By signing below, I am stating that I have no insurance coverage for today's visit and therefore, I am responsible for all charges incurred. Payment in full is expected at each visit.

_____ _____

Signature of Patient/Customer or Parent/Guardian Date

Sharing and/or Releasing My Medical Information

If you would like Simpson Optical to be able to discuss your medical records and/or billing information with a spouse or other family member, **please let us know** so you can sign our HIPAA Compliant Release Form.

Communicating My Medical Information

Simpson Optical may need to communicate medical information regarding your treatment, testing and/or appointments. I give my permission to have this information communicated to me via: __ Voicemail __ Email __ Mail __ Any of these

_____ _____

Signature of Patient/Insured or Parent/Guardian Date

Do NOT Share My Medical Information

By signing below, I acknowledge that I was given the opportunity to share my medical information with a third party. However, I do NOT want any aspect of my medical or billing information shared with anyone without my prior written authorization.

_____ _____

Signature of Patient/Insured or Parent/Guardian Date

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Shared Release

Patient Name: _____ DOB: _____

DO NOT SHARE INFORMATION

I acknowledge I have been given the opportunity to share part or all of my medical record with a third party (non-medical/insurance provider). However, ***I DO NOT*** wish to have any information shared outside of what is allowed by HIPAA without my signed consent.

Signature: _____ Date: _____

SHARE INFORMATION

I give Simpson Optical permission to release the following information to the individual(s) listed below. I further understand that I can revoke this authorization at any time. This revocation MUST be in writing.

(Only fill out line below if release request is LESS than 1 year)

I would like this release to be valid from _____ to _____ only.

Please mark beside each item you would like to give access:

____ Medical Records (includes testing, results, personal health/family history and medications/allergies)

____ Billing/Financial/Insurance information

____ Demographic (personal) information

____ All items listed above

Simpson Optical may need to communicate medical information regarding your treatment, test results and/or referral appointments. I give my permission to have this information communicated to me via:

__ Voicemail __ Email __ Mail __ Any of these

Please list who you would like to give access (please print):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature Date