Insurance Authorization, Binding Financial Agreement, and Privacy Notice for:

BABCOCK EYE CARE

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Please print patient's name

Providing the best possible eye care involves a mutual understanding between patient and provider. Please review the following policies, and let us know if we can answer any questions. Thank you for your trust.

- I authorize Babcock Eye Care to release information regarding my care to my insurance company in order to expedite claims or for records transfer should such events be required.
- I authorize Babcock Eye Care to bill my insurance company for services provided to me, with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- I understand that Babcock Eye Care participates with both Vision Plans (ex. VSP, EyeMEd, etc.) for routine wellness exams, as well as Medical Insurances (ex. Medicare, Anthem, BCBS, PPOs etc.) for eye health issues. The appropriate plan will be billed for any given service. I understand that if Babcock Eye Care does not participate with my plan, I am free to pay out of pocket at the time of service and seek any out-of-network reimbursement directly from my insurer.
- While Babcock Eye Care makes every effort to verify my insurance coverage and benefits before services are provided, I understand that such information is NOT an official or legally binding decision of my out-of-pocket expenses. Verification of coverage is done as a courtesy only, and is not a guarantee of insurance coverage. Ultimately, my final costs are dependent on the final decision of my insurance carrier. I understand that if my insurer does not pay, or only partially pays, I am responsible for payment in full of any remaining balance for services rendered.
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- **Contact Lens Service Fees**: I understand contact lens services are not an included part of a comprehensive eye health examination, and may or may not be covered by vision plan benefits. I understand that in addition to the contact lens fitting fee there may be additional fees according to lens type and services required.

Notice of Privacy Practices

By signing below you acknowledge and agree that Babcock Eye Care may use or disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations. If you would like to view our full Notice of Privacy Practices for a description of such possible uses and disclosures, please ask our front desk staff. You have the right to review the Notice before signing below. You have the right to request that you restrict how you use or disclose PHI to carry out treatment, payment or healthcare operations. You will not be required to agree to requested restrictions, but if you do, it will be binding on you. You have the right to revoke the consent in writing, except to the extent that you have taken action in reliance upon the consent. These policies are subject to change or modification without notice.

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Patient signature, or legal guardian if patient is under 18 Date