Cynthia Phelps, O.D

Informed Consent & Treatment Authorization

The law requires that we make every effort to inform you of your rights related to your personal health information.

- *I have read or had explained to me the Notice of Privacy Practices for Cynthia Phelps, O.D and agree to continue my care with Cynthia Phelps, O.D under said terms.*
- *I was given the opportunity but declined to read the Notice of Privacy Practice, for Cynthia Phelps O.D but wish to continue my care with Cynthia Phelps O.D under the terms of her privacy policies.*
- *I have read or had explained the Notice of Privacy Practices for Cynthia Phelps O.D and do not wish to continue my care with Cynthia Phelps under said terms.*
- *The Notice of Privacy Practices could not be read due to the emergent nature of the care or the reason described as:*

  _____
- *I (do)____(do not)____ authorize Cynthia Phelps O.D; or her staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.*
- *I (do)___ (do not)___ authorize Cynthia Phelps O.D; or her staff to leave a message at my place of employment.*

ɛnt or Legal Guardian Signature_____Date_____

Financial & Insurance Filing Policy

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
- *If your insurance company doesn't pay your claim within 30 -45 days it is your responsibility to contact them to expedite payment. We will require you to pay the balance by cash, check, money order or credit card.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

Authorization To Release Health Information & Assign Benefits

I hereby authorize Cynthia G. Phelps, O.D to provide diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrist in order to facilitate continuity of care.

I _____, authorize the release of all necessary Protected Health Information & assign all al & vision benefits to Cynthia Phelps O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my to Cynthia Phelps, O.D for any services furnished to me by Cynthia Phelps, O.D. I authorize any holder of medical information related to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the ts payable to related service. I understand that my signature requests that payment be made & authorizes release of medical information ɜary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the r or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full ɜ, & the patient is responsible only for the deductible, copay, & non-covered services. I understand that I am ultimately responsible for ll incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fee, court costs & collection ɜs .There will be a service charge for each returned check. The authorization & assignment will remain in effect until revoked me in ɜ, A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have l to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this ɪation & I am signing voluntarily.

ɪt or Legal Signature_____ Date_____