

# ZELENAK EYE INSTITUTE

— JONATHAN ZELENAK D.O. —

## NEW PATIENT HIPAA CONSENT & CONSENT FOR TREATMENT

### Authorization to access electronic prescriptions:

I hereby authorize Zelenak Eye Institute to view my external electronic prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years and may include prescriptions to treat substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my medical record.

### Authorization for Photograph and Use in Medical Records:

I hereby authorize and consent to the taking of photographs or pictures of me by and its agents or employees, and the use and storage of such photographs for identification purposes and as part of my medical record. I hereby release Zelenak Eye Institute, its staff, agents, and employees from all liability related to the making, storage, and use of such photographs for identification purposes as part of my medical Zelenak Eye Institute record.

### Referral to outside providers:

You understand and agree that if your insurance company requires you to have a referral for service provided by out of network providers, you are responsible for obtaining this. The physician(s) and provider(s) at Zelenak Eye Institute may refer you to providers that are out of network for you. If you desire to be referred only to in-network providers, then you may contact your insurance company for a list of active in-network providers for the relevant service and we would be happy to help you select from within that list.

### Consent to Treat:

I, the undersigned, voluntarily consent to and authorize through its physicians, employees and/or agents to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiologic, and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my Zelenak Eye Institute physician(s), including, but not limited to, collecting and testing of bodily fluid, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

### Consent to Treat (cont):

I consent to pharmacologic dilation of my eyes with the use of eye drops. I understand that this is a very commonly performed step in ophthalmic examinations, but that there are uncommon but potentially serious side effects. These may include, but are not limited to, angle closure and glaucoma, headache, cardiac arrhythmia (usually temporary if it occurs), and hypopnea. **IF I AM PREGNANT OR THINK I MIGHT BE PREGNANT, I WILL NOTIFY THE STAFF MEMBER OR PHYSICIAN IN PRIVACY BEFORE DILATION DROPS ARE INSTILLED IN MY EYES.** While dilation drops are likely to be generally safe during pregnancy due to the small quantity and route of administration, extra precautions are taken during pregnancy to minimize and/or delay exposure.

### Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the provider(s) in Zelenak Eye Institute for the services rendered on my behalf. I understand that I am financially responsible for all charges, whether I am insured at the time of service, including deductibles, co-insurance, co-payments, and benefit services that are out of network, denied and/or not covered by my health insurance plan. I authorize Zelenak Eye Institute or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross or any other insurance carriers or their authorized agents any information needed for this or a related claim.

### Financial Policy

We strive to provide our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates. We ask for your help by understanding and cooperating with our Financial Policy.

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company AND your doctor's bill for services provided is an agreement between you and your doctor.

**YOUR Responsibility:** Our physician(s) participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self-pay" and ask for full payment.

All co-payments, co-insurances, deductibles, and payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

**Referrals:** If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment of services provided if you fail to supply all required referral forms.

Acuity of need:

ALL INSURANCE PLANS, including but not limited to Medicare Replacement Plans, Managed Care and Commercial Carrier Plans: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent you will be responsible for paying the fee for all services at the time of service.

Payment for Services Performed:

Our office accepts Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards, and Personal Checks for payment of service. A small service charge may be applicable to all credit card and debit card transactions, and you will be advised of such charge at the time of payment should you use one of these methods.

Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.

All payments re expected at the time of service. Should your account require action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

RETURNED CHECK FEE IS \$40

CHARGES TO ACCOUNT: We shall retain the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: We reserve the right to charge patients who do not show up for an appointment or fail to reschedule or cancel with the less than 24 hours' notice a \$50.00 no-show fee. This will be due before another appointment can be made. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

RIGHT TO AMEND: You understand and agree that Zelenak Eye Institute may amend the terms of this Financial Policy at any time without prior notification to the patient.

Health Insurance Portability and Accountability:

I acknowledge receipt of the Notice of Privacy Practices (Health Insurance Portability and Accountability).

I agree that I have read this form, any questions have been answered, and I understand and agree to its content.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_