WILSON EYECARE

126 W 2nd Ave
Williamson, WV 25661
Phone: (304) 235-2020
Fax: (304) 235-8665
www.wilsoneyecare.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE: _____ Social Security #: _____

PATIENT ADDRESS: _____ Email Address: _____

_____

The professional office named above is authorized to release or obtain health information identifying you under the following terms and conditions:

1) A detailed description of the information to be released.
2) The person/practice to which the information will be released.
3) The purpose for the release of information.
4) The expiration date of the event.

It is completely your decision whether or not to sign this form. If you choose not to sign this authorization, you can be refused treatment. You can also review your health information that we have on file before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the privacy officer, **LORA LAWRENCE**, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the privacy officer, **LORA LAWRENCE**.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____ _____
SIGNATURE DATE

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
PRINT NAME RELATIONSHIP

_____
SOURCE OF AUTHORITY

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

PATIENT/BENEFICIARY (print): _____ DOB: _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits to be made on my behalf to Wilson EyeCare for services furnished to me by Dr. Steven C. Wilson or Dr. G. Shawn Sammons. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurance or agency shown. Wilson EyeCare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.
2. **OTHER INSURANCE:** I understand that Wilson EyeCare maintains a list of healthcare service plans with which it contracts. A list of such plans is available from the business office. And that Wilson EyeCare has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services to me by Wilson EyeCare if I belong to a plan that does not appear on the above-mentioned list.
3. **NON-COVERED SERVICES:** I understand that Wilson EyeCare contracts with healthcare services plans (i.e., HMOs, PPOs) related only to items and services, which are "covered" by the healthcare service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the healthcare service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a healthcare service plan or in the benefit summary the healthcare service plan furnishes to the patient; and treatment or tests not authorized by the healthcare service plan. The undersigned agrees to cooperate with Wilson EyeCare to obtain necessary healthcare service plan authorizations.
4. **FINANCIAL AGREEMENT:** I understand that I am responsible for all charges at time of service and that there is no guarantee of payment from any insurance company or any other payer. I understand that some routine services are not covered by my insurance and that I am financially responsible for all charges at time of service. I agree to pay all charges for the services provided by Wilson EyeCare which are not paid by my health insurance or other payer. I authorize Wilson EyeCare to keep my signature on file and to charge my credit card on record for all remaining balances after insurance claims is/are resolved. This includes co-pays, deductibles, glasses, contact lenses, and any denied claims. I agree to pay all interest charges, late fees, and reasonable legal expenses necessary to the collection of any debt. I understand that I am responsible for a $25 returned check fee in addition to any other associated bank charges. Alternatively, I understand that I can pay all fees in full today and, in the event of overpayment, can expect refund within 25 days of Explanation of Benefits (EOB) from my insurance to Wilson EyeCare. If refund is less than $10, Wilson EyeCare will leave a credit on my account and send notification of such to me.

_____ _____

BENEFICIARY SIGNATURE OR AUTHORIZED PARTY DATE