JACQUELINE CO, M.D., PA

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by **JACQUELINE CO, M.D., P.A.** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
JACQUELINE CO, M.D., P.A. is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, **JACQUELINE CO, M.D., P.A.** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or **JACQUELINE CO, M.D., PA** if you would like additional information or clarification.

It is a violation of the federal privacy standards if **JACQUELINE CO, M.D., PA** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy brochure, please consult with a practice representative or **OFFICE MANAGER** at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, **JACQUELINE CO, M.D., PA** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
JACQUELINE CO, M.D., PA reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. **JACQUELINE CO, M.D., PA** will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE (on page #2)
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **JACQUELINE CO, M.D., PA** to use and disclose my health information in accordance with this consent and the notice provided.

JACQUELINE CO, M.D. P.A.,

OFFICE & FINANCIAL POLICES

We are dedicated to providing the best possible ophthalmic care and services to you, your complete understanding of your responsibilities is an essential element of your care and treatment, if you have any questions about the following policies please do not hesitate to discuss them with us.

FEES: The patient is responsible for all accounts regardless of insurance coverage within 30 days after the day of treatment. We make every effort to follow the guidelines required by your insurance company; however, every contract is unique. Every effort is made to files claims electronically in your behalf with your insurance company. Unfortunately if we are unable to collect payment from your insurance company within 30 days, you will be financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

GUARANTY OF PAYMENT: As a courtesy to our patients we will file your primary insurance claims electronically for HIPPAA Regulations, this does not guarantee payment from your insurance until your claim is processed by your insurance carrier. Because every insurance contract is unique, you are responsible for any unpaid portions including but no limited to co-payment (due at the time of service) and unmet patient portions (deductible, patient percentage, exclusion clause such as pre-existing condition etc.) Unmet portions will be handled in two ways:

_X__ 1 the entire unmet portion is due at the time of service
_X__ 2 A credit card imprint will be kept on file as guaranty of payment. Once a response is received from your insurance carrier, you will be sent one billing statement for any balance due. You will have 30 days from the statement date in which to pay the balance in full. If payment has not been received within 30 days, you understand and agree that the past due balance will be charge to your credit card on file. Should your credit card payment be declined for any reason and you fail to make satisfactory arrangements for payment within 15 days, you account will be referred to outside collection. You are responsible for any legal fees.

MEDICARE PATIENT without electronic-cross-over secondary insurance: For HIPPA regulations, this office cannot file secondary/supplemental insurance paper claims. If your secondary insurance carrier does not accept electronic automatic cross-over claims from Medicare, you are financially responsible for the remaining 20% at the time of service as required by Medicare.

SELF-PAYMENT-PATIENT: This office does not accept any payment plans for services rendered on self-pay patients and all balance are due at the time of service.

VALID DRIVER'S LICENSE: for your convenience we accept cash, check, Visa, Master card, Discover. Payment made by either check or credit card must be accompanied by a driver's license.

SERVICE CHARGE: A $25 service charge will be assessed for returned checks, and must be paid by cash or certified funds.

CANCELLATION POLICY-It is the office policy to bill the patient (not the insurance company) a $25 fee for any missed appointment without 24h hours prior cancellation. This amount must be paid in full prior to rescheduling another appointment. As a courtesy to the patient, we will make reasonable attempts to confirm appointments. Since it is not always possible, it is the patient's responsibility to keep track of appointment. Please call us as early as possible to reschedule appointment.

MEDICAL RECORDS- A copy of medical records will be furnished to a physician or patient upon written request from the physician or patient. An authorization for release of medical records form must be completed and signed by the patient. A fee will be accessed to the patient for this request and must be paid in full prior to the release of records. Please allow 3-5 business days for these copies

I have read and understand the financial policies of the practice and I agree to be bound by its term. I also understand and agree that such terms may be amended from time to time by the practice.

NAME OF PATIENT:

SIGNATURE OR RESPONSIBLE PARTY: