BoozmanHof
WORLD CLASS EYE CARE

Patient Name: _____ Social Security #: _____

Notice of Privacy Practices (HIPAA)
Patient Acknowledgement

I am a patient or legal guardian of a patient of BoozmanHof Regional Eye Clinic, P.A. I hereby acknowledge receipt of BoozmanHof's Notice of Privacy Practices.

Name (please print): _____ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian

Patient / Guardian Signature: _____ Date: _____

Administrative Policies
Patient Acknowledgement

I acknowledge that I have received a copy of the practice's Administrative Policies form and have been given the opportunity to ask questions. By signing below, I am acknowledging I have read and understand the Administrative Policies.

Name (please print): _____ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian

Patient / Guardian Signature: _____ Date: _____

Assignment of Benefits and Financial Agreement
Patient Acknowledgement

I acknowledge that I have received a copy of the practice's Assignment of Benefits and Financial Agreement form and have been given the opportunity to ask questions. By signing below, I am acknowledging I have read and understand the Assignment of Benefits and Financial Agreement.

Name (please print): _____ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian

Patient / Guardian Signature: _____ Date: _____

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Signature on File, Assignment of Benefits, Financial Agreement

1. Medicare: I request that payment of authorized Medicare benefits be made on my behalf to BoozmanHof Regional Eye Clinic, P.A. (BoozmanHof) for services furnished to me by BoozmanHof. I authorize any holder of medical information about me to release to the 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 the 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 or other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. BoozmanHof accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.

2. Medigap: I understand that if a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes the release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to BoozmanHof, if possible or otherwise to me.

3. Release of Information: BoozmanHof may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to BoozmanHof for reimbursement for services rendered, and 2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original. 3) Family members unless otherwise indicated by the patient. I have received a copy of the Notice of Privacy Practices.

4. Other Insurance: I understand that BoozmanHof maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that BoozmanHof 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 rendered to me by BoozmanHof if I belong to a plan that does NOT appear on the above-mentioned list.

5. Non-Covered services: I understand that BoozmanHof contracts with Health Care service plans (i.e., HMOs, PPOs) state items and services, that are "covered" by the healthcare service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care 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 health care service plan or in the benefit summary in the health care service plan furnished to the patient, and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with BoozmanHof to obtain necessary health care service plan authorizations.

6. Financial Agreement: I agree that in return for the services provided to the patient by BoozmanHof, I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time service is rendered, or I will make financial arrangements that day satisfactory to BoozmanHof. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. Any benefits of any type under any policy of insurance ensuring the patient or any other party liable to the patient is hereby assigned to BoozmanHof. If deductibles and/or co-payments are designated by my insurance company or health plan, I agree to pay them to BoozmanHof. *However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.*

7. Authorization: I authorize the Doctors and Staff at BoozmanHof to examine my eyes and perform any services normally associated with an eye examination.

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Administrative Policies

Co-Pay and Prior Balance Policy
Co-payments and any prior account balances will be collected on the day of service. You may be asked to pay your prior balance upon check-in. Your co-pay for the services rendered will be collected at check-out as well as any prior balance, if not collected at check-in. If for any reason payment is not collected on the day of service, you will receive a statement in the mail.

Returned Check Policy
Your account will be assessed a fee of $25.00 for a check that is returned to us for non-payment.

FMLA and Disability Paperwork Policy
Requests for our office to complete paperwork for a patient's employer or insurance company will be assessed a fee of $25.00. This fee will be collected when the paperwork is provided to us for completion. The completed form will be released to the employer, insurance company, or patient as long as the payment has been made to the clinic.

Late Arrival Policy
If a patient is late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate latecomers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

Missed Appointment Policy
While we make every effort to provide a reminder call/text at least 24 hours before your appointment, it is your responsibility to remember your appointment. We may charge a $35.00 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel less than 24 hours in advance. Fees must be paid before a new appointment can be scheduled. After three (3) missed appointments, the practice may, at its discretion, choose to discontinue your care.

The doctors and staff at BoozmanHof truly appreciate your compliance and understanding with our Administrative Policies so that we can continue to provide excellent medical care as well as excellent customer service.