Aurora Optometric Group

980 West Maple Court Elma, NY 14059 716-652-0870 Fax 652-2071

Keith Del Prince, O.D Shawn Clancy, OD Amy Suda, OD Patricia Miller, OD Katie Del Prince, OD

ACKNOWLEDGEMENT OF RECEIPT AND GENERAL CONSENT

The Health Insurance Portability and Accountability Act requires all health care entities to enforce privacy guidelines and make these available for their patient's review. The following statement acknowledges your understanding of these privacy efforts:
I acknowledge that I received, or was furnished upon my request, a copy of the Privacy Practices for the Aurora Optometric Group P.C. I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by the law under the circumstances described in the Notice of Privacy Practices.

SIGNATURE ON FILE AND FINANCIAL RESPONSIBILITY AGREEMENT

NON-COVERED SERVICES: I understand that the Aurora Optometric Group P.C. maintains a list of health care service plans (i.e. HMOs, PPOs) that state items and services that are "covered" by the health service plans. Accordingly, the undersigned accepts full financial responsibility for all items and 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 the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan.
FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by the Aurora Optometric Group P.C., I will pay my account at the time services are rendered or will make financial arrangements satisfactory to the Aurora Optometric Group P.C. for payment. If an account is sent to a collection agency for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to the Aurora Optometric Group. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Aurora Optometric Group P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Name (printed)

Legal Guardian, Power of Attorney, or Responsible Party's Name (printed)

_____ DATE: _____

Responsible Party, Beneficiary, or Power of Attorney signature

Email Address: