Name:
DOB:
Chart:
Age:
Date:

RECEIPT OF THE NOTICE OF THE PRIVACY PRACTICE

We receive the right to modify the practices outlined in the notice.

A copy of the Notice of Privacy Practices is located in our office

You may contact me at work ☐ Y ☐ N
You may leave a message regarding my appointment on my answering machine ☐ Y ☐ N
You may leave a message regarding my appointment with _____
You may leave a message regarding medical information with _____

Patient Financial Policies

As you know, health care is in a state of constant change. In order to help you with these changes we require you to present your most recent insurance card at each visit. If you do not have your insurance cards, payment in full is required at the time of your visit.

I understand I am financially responsible for all services rendered. It is my responsibility to be aware of the rules and regulations imposed by my insurance carrier.

I understand this office participates with certain health insurances. If my insurance is accepted, they will bill my insurance. I am responsible for any deductible, copays and payment for non-covered services at the time of my visit. A fee of $10.00 may be charged for all copays not paid at the time of service.

I understand if a referral is needed for treatment and I do not obtain one prior to my appointment, I will not be seen.

I understand if unable to keep a scheduled appointment, we kindly request that you give a 24 hour notice. If less than 24 hours notice is given, we may charge a $35.00 missed appointment fee.

I understand a fee of $25.00 will be charged for all returned checks.

If it becomes necessary for Thames Eye Group, P.C. to forward my account to a collection agency, I understand that I will be responsible for all collection fees.

I understand the policies stated above and accept responsibility for payment of all charges incurred.

Signature of Patient or Guardian Date