Bowen Eye Care

Privacy Disclosure Policy and Transaction Policy

Acknowledgment of Receipt Notice of Privacy Practices

Print Patient Name _____ DOB_____-_____-_____

Preferred Phone Number(s) _____Cell or Home Email _____

Address_____

By signing this document, I hereby give permission to Bowen Eye Care to notify me regarding my Appointment(s), Eye Wear Order(s), Patient Recall(s) and Insurance Information in any or all of the following manners: With the Preferred Phone Number(s) given above, Answering Machine, Voice Mail, and/or Email.

Medical Lab Results, Pathology Results, or any Health Information not otherwise considered "business as usual" will only be divulged to the patient or to the specific individual(s) listed below. Only the patient, unless a minor, may request copies of his/her Medical Record.

Name_____ Relationship _____

Name_____Relationship_____

Primary Care Physician (PCP) _____ Phone_____

I acknowledge that Bowen Eye Care has policies in place that protect my private information in accordance with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA, Title II**) and I hereby grant Bowen Eye Care the authorization to share whatever private information is "deemed necessary" in order to bill my insurance company and to process my eyewear orders. I also acknowledge that all payments are due, at the time services are rendered, unless other arrangements have been made in advance. I understand that Bowen Eye Care will submit Medical and Vision Insurance claims for any benefits for which they are providers for if all pertinent information has been given prior to the day of the appointment. In the event my insurance company denies a claim, the person responsible for my account accepts responsibility for the charges. I understand the accounts **90 days past-due** are subject to collections fees and that there is a $35.00 service charge on all returned checks. Any payments from my insurance company are to be paid directly to Bowen Eye Care. I understand that all insurance benefits quoted to me by Bowen Eye Care are not a guarantee of payment by my insurance company and that a **final determination can only be made when the claim is processed.**

This is notification of our **Transaction Policy**. Every effort has been made to discover our patient's insurance benefit coverage. However, final determination of your responsibility can only be made once the insurance processes the claim. We reserve the right to amend credit card charges to reflect the insurance company's findings. We are happy to provide a copy of the benefits explanation at your request. If you have concerns about future expenses appearing on your account, the alternative option is to pay the balance in full at the time of service and then receive a refund once the claim is processed.

Print Name_____ Signature_____ Date _____

I understand that I am entitled to receive a copy of this document for my personal records.
I understand I may revoke this consent at any time by giving written notice to Bowen Eye Care regarding disclosure(s).