ROBERT H. CHU, M.D., P.A. **Montgomery Eye Center**

Diseases and Surgery of the Eye

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Use and Disclosure of Protected Health Information

I. Patient Acknowledgement & Consent Form

Copies of our "Notice of Privacy Practices" provides information about how Robert H. Chu, MD, PA (aka Montgomery Eye Center and 20/20 Optical), hereinafter referred to as the "Practice," may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date in our office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

II. Consent For Use and Disclosure of Information

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to the Practice for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and /or any other Insurance Carrier for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of services in accordance with the contracted Insurance Carrier agreement. By signing below, I acknowledge receipt of Notice of Privacy Practices and consent to the Practice's use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the Practice has already made disclosures in trust on my prior consent.

X_____

Patient's Signature Print Full Name Date

III. Personal Representative, Family or Other Entities Authorized Access to Protected Health Information to be Used and/or Disclosed:

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	Relationship	Phone #
Name of Authorized Person or Entity	Relationship	Phone #

IV. Authorization for use of Answering Machine and/or Voice Mail:

The Practice may be unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

☐ Yes, I agree to allow the Practice to leave messages that include Protected Healthcare Information on any of the three communication devices: home, work, and/or cell phone.

☐ No, I do not agree to allow the Practice to leave messages that include Protected Healthcare Information on my home, work and cell phone.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

I _____hereby authorize Robert H Chu, MD, PA to apply for benefits on my behalf for covered services rendered. 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 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 on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Robert H Chu, MD PA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

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 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 Robert H Chu, MD PA.

Robert H Chu, MD PA may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, communicable disease, or HIV, to any person or corporation which is or may be liable or under contract to Robert H Chu, MD PA for reimbursement for services rendered, and any health care provider for continued patient care. Robert H Chu, MD PA may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal law. A copy of this authorization may be used in place of the original.

I understand that Robert H Chu, MD PA 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 Robert H Chu MD PA has no contract, expressed or implied, with any plan that does no appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Robert H Chu, MD PA if I belong to a plan that does not appear on the above mentioned list.

I understand that Robert H Chu, MD PA contracts with health care service plans (i.e. HMOs, PPOs) state items and services which are “covered” by the health care 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 the health care service plan furnishes to the patient; and treatment or tests not authorized by eh health care service plan. The undersigned agrees to cooperate with Robert H Chu, MD PA to obtain necessary health care service plan authorizations.

I agree that in return for the services provided to the patient by Robert H Chu, MD PA, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Robert H Chu, MD PA for payment. All delinquent unpaid balance earns interest at 1.5% per month. Should any amount due be referred to attorney or collections, I agree to pay the additional finance charge and all court costs (if applicable) plus reasonable attorney’s fees. I agree to pay a $25 charge for returned checks. Benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Robert H Chu, MD PA. If copayments and/or deductibles are designated by the insurance company or health plan, I agree to pay them to Robert H Chu, MD PA. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.***

Date_____ Signature of Subscriber or Beneficiary X_____