Kaster Eye Clinic
Optical & Vision Care

3705 Massillon Road, Uniontown, OH 44685
Phone: 330-899-7161 Fax: 330-899-7151

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Kaster Eye Clinic, Notice of Privacy Practices.

Patient Name (print): _____

Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Kaster Eye Clinic. I understand that _____ will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature: _____ **Date:** _____

OPTIONAL - CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Kaster Eye Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kaster Eye Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised version may be obtained by forwarding a written request to Kaster Eye Clinic - 3705 Massillon Rd. Uniontown, OH 44685.

With this consent, Kaster Eye Clinic may call, mail, or e-mail my home of other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any correspondences pertaining to my clinical care, including laboratory test results, among others.

By signing this form, I am consenting to allow Kaster Eye Clinic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kaster Eye Clinic may decline to provide treatment to me.

Other individuals my PHI may be discussed with:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Your Name: _____ **Signature:** _____ **Date:** _____