PREMIER EYE
ASSOCIATES

PATIENT INFORMATION	
First Name:	Last Name:
Preferred Name:	Phone Number:
Email:	Date of Birth:
Social Sec #:	Occupation:
Marital Status:	Sex:
Address:	City:
State:	Zip:

PARENT / GUARDIAN INFORMATION (IF UNDER 18)	
Name:	Phone:
Relationship to patient:	

HEALTH INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:
Policy Holder's Phone Number:	

VISION INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:

POLICIES & PRACTICES AGREEMENT

COMMUNICATION: I consent to allow office staff to call, text, or email me.

CONSENT FOR TREATMENT: I authorize Premier Eye Associates to perform any necessary services that I may need during diagnosis and treatment.

CONTACT LENSES: If you are having any discomfort or blurry vision with your contact lenses, we will happily recheck your prescription at no cost within 30 days of you receiving your lenses. After 30 days, a new Contact Lens Exam fee and Refraction Fee will be charged.

FEES: Premier Eye Associates reserves the right to charge a cancellation fee to patients who miss or reschedule appointments without giving at least 24 hours' notice. For any payments, a $20 fee will be charged for any checks returned due to insufficient funds.

GLASSES REMAKES: All remakes must be requested within 30 days of the dispense date. Glasses are eligible for 1 free remake and refraction within 30 days. If you wish to have further remakes, you will owe a 50% fee (50% of the retail cost of the lenses) per remake as well as a Refraction fee if you would like to have your prescription checked again. I have read, understand, and agree to the previously stated glasses remake policy.

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Patient Signature (Guardian if under 18) Date

LATE PAYMENTS AGREEMENT: For each month over 30 days past due a 10% late fee will be added to outstanding balances. After 60 days past due all outstanding balances will be sent to collections. Patient assumes all collections and attorney fees related to collecting outstanding balances. Patients are responsible for all collections fees once balances are turned over to collections, even if payment is made directly to Premier Eye Associates. This Agreement shall be construed under the laws of the State of Alabama and venue for any proceeding arising from this agreement shall be in Lee County, Alabama.

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Patient Signature (Guardian if under 18) Date

INSURANCE: At Premier Eye Associates, we happily submit claims to your insurance company. We do our best to estimate your insurance coverage and out of pocket costs, but please remember that it is just an estimate. Ultimately, you are responsible for any outstanding balances. Payment of your insurance deductible, co-payment, and/or coinsurance is due and collected on the date of service.

RECORDS: All requests for copies of records may take up to 5 business days to process.

REFERRALS: If a referral is required by your insurance to cover any services or products provided by Premier Eye Associates, it is your responsibility to obtain those referrals prior to your visit.

REFUNDS AND EXCHANGES: All sales are final and there will be no refunds or exchanges on professional services or products. If using your insurance, your insurance will be filed at the time of purchase. Once insurance is filed and benefits are used, Premier Eye Associates is not responsible for contacting any insurance to reverse the filing. I have read, understand, and agree to the previously stated refunds and exchanges policy.

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Patient Signature (Guardian if under 18) Date

HIPPA: PRIVACY POLICIES & PRACTICES

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
- **Insurance**: You authorize Premier Eye Associates to release medical information about you to your insurance providers to determine benefits or the benefits payable for related services.
- **Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders
- (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

AKNOWLEDGEMENT

I have read, understand, and agree to this entire Policies and Practices Agreement. This Agreement shall be construed under the laws of the State of Alabama and venue for any proceeding arising from this agreement shall be in Lee County, Alabama.

_________________________________ _________________

Patient Signature (Guardian if under 18) Date

Premier Easy Pay

Premier Easy Pay provides you the convenience of saving a card on file to pay any outstanding balances rather than having to mail us a check! We run all our payments through our HIPAA-compliant, secure practice management software. Office personnel will not have access to your card information. For your protection, only the last 4 digits of your card will show in our system. Not only does Easy Pay save you time, but it helps you avoid any late payment fees!

AFTER YOUR INSURANCE PROCESSES: IF YOU OWE A BALANCE

BALANCE $50.00 OR LESS
- Credit card on file is automatically billed.

BALANCE OVER $50.00
- Statement sent - payment due within 14-days
- Payments not received after 14-days, card on file billed

LATE PAYEMENTS
- 10% late fee added per month
- Collections after 60 days. Patient assumes 33% collection fees

Other Patients Card is Approved For	Relationship

Please check one option below

	I would like to enroll in Easy Pay and have my card on file automatically charged for any outstanding balances.
	I do not want to enroll in Easy Pay. I prefer to mail a check.

___________________________________ ________________ ___________________________________

Cardholder Signature Date Cardholder Email

Credit Card Last 4

=======================================STAFF ONLY=====================================

	Form scanned into Crystal

Premier Easy Pay

If you would like to enroll in easy pay, please enter your card information below. This form will be shredded and will not be stored on file.

To Be Shredded

Account Type: ____ Visa ____ Mastercard ____ America Express ____ Discover

Cardholder Name: ____

Credit Card Number: ____

Expiration Date: ____

Security/CVV: ______________________ **Billing Zip Code**: ______________________

Authorization to Release Medical Information

Patient First & Last Name: _________________________________ Date of Birth: ____________

I hereby authorize medical providers and personnel of Premier Eye Associates to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: ___________________________________ Relationship: ______________________

Name: ___________________________________ Relationship: ______________________

Name: ___________________________________ Relationship: ______________________

Name: ___________________________________ Relationship: ______________________

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the office has relied on the use or disclosure of protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

____________________________________ ________________________

Signature of Patient or Personal Representative Date

____________________________________ _________________________

Print Name of Patient or Personal Representative Relationship to Patient