INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is YOUR RESPONSIBILITY.

- I authorize Dr. Breedlove to release any information regarding my care to expedite claims or for records transfer should such events be required.
- I hereby authorize Dr. Breedlove to bill my insurance company for services provided to me and with payment made directly to this office and that such authorization is valid until written notice is provided to cancel that authorization.
- **While this office makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO DR. BREEDLOVE FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS CO PAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 45 days it is my responsibility to pay the bill and that I will pay collection fees, attorney's fees, court costs, etc., for the purpose of collection on delinquent accounts.**
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to Dr. Breedlove's office.
- **I understand there may be medical findings during the course of my exam that may require treatment. I understand it a VIOLATION of Dr. Breedlove's provider agreement with my insurance to bill such medical services to my Vision Wellness Plan. In this event, my medical insurance will be billed and I will be responsible for any applicable copays, cost-shares, and/ or deductibles.**
- I understand there is a $50.00 fee for all returned checks.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Signature:_____ Date:_____

PATIENT PRIVACY ACKNOWLEDGEMENT

Notice of Privacy Practices is about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. You have the right to review our Notice before signing this consent. By signing this form, you consent to our use and disclosure of your protected health information about you for treatment, payment and health care services. I hereby authorize Dr. Breedlove's office to release any medical information or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes, but is not limited to, my insurance company.

Signature:_____ Date:_____

BREEDLOVE EYE CENTER
WELCOME TO OUR OFFICE!

Last Name _____ First _____
Cell Phone _____ E-mail address _____

How Did You Hear About Our Office?
__Insurance __Internet __Location
__ Physician __Advertising
__Referral - Whom May We Thank? _____

Do You Currently:
Wear Glasses? *Yes / No* How Old? ___ Wear Polarized Sunglasses? *Yes / No*
Wear Contact Lenses? *Yes / No* What Brand? _____

Are You Interested In:
New Eyewear? *Yes / No* Trying Contact Lenses? *Yes / No*
Learning More About Non-Surgical Vision Correction? *Yes / No*

Have You Ever Had:
__ Cataract Surgery __ Retinal Surgery __Lasik __Other Eye Surgery

Do You Currently Experience Any Of The Following:
__Blurred Vision __Burning __Dryness __Excessive Tearing
__Eye Pain/Soreness __Itching __Discharge __Redness
__Flashes of Light __Floaters __Sandy Feeling __Glare
__Sensitivity __Sudden Vision Loss __Double Vision

Vision and Medical History:
Have you or a family member experienced any of the following? Check all that apply.

Condition	You	Family Member	Condition	You
Cataracts			High Blood Pressure	
Diabetes			Heart/Carotid	
Glaucoma			Headache/Migraine	
Macular Degeneration			Skin Conditions	
Eye Injury			Arthritis	
Amblyopia/Lazy Eye			Neurological/MS	
Keratoconus			Sinus Problems or Allergies	
Retinal Detachment			Hormonal/Thyroid	

Please List All Medications:
_____

Please List All Allergies, Including Drug Allergies:
_____