Old Saratoga eyecare

MEMBER Vision Source NETWORK

Acknowledgement of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

The law requires that Old Saratoga Optometry & Ophthalmic Dispensing, PLLC make every effort to inform you of your rights related to your personal health information. This information is posted in the waiting room on the wall by the television. By my signing electronically, I acknowledge that I was given the opportunity to read, have read, or had explained to me Old Saratoga Optometry & Ophthalmic Dispensing, PLLC's Notice of Privacy Practice prior to any services offered.

I authorize Old Saratoga Optometry & Ophthalmic Dispensing, PLLC to release my personal health information to the following individuals noted below as Authorized Users as well as my Medical and Vision Insurance Companies.

I authorize Old Saratoga Optometry & Ophthalmic Dispensing, PLLC to communicate via text or email. Although HIPPA compliant, I am aware messages or emails may not be encrypted, and complete privacy cannot be guaranteed.

If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor. Please inform staff of any other parent, stepparent, guardian or other individual(s) authorized to make medical decisions for the minor.

If you are not the holder of your insurance, the guarantor must be noted as an Authorized User in your Electronic Health Record. Your emergency contact must also be noted as an Authorized User.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Authorized Users:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient / Parent or Legal Guardian Date

* Co-Managing Doctors are automatically included and do not need to be individually listed. Rev 09/24

Old Saratoga Eyecare
1224 State Route 29
Greenwich, NY 12834

(o) 518-692-2040
(f) 518-692-2440
www.oldsaratogeyecare.com

Patient Agreement and Office Policies:

ASSIGNMENT OF BENEFITS: Insurance coverage is a contract between you and the insurance company you participate with. We can "estimate" what your insurance company may pay. However, it is your insurance company that makes the final determination of your eligibility and coverage. By signing this form, you authorize and direct payment of your medical benefits to Old Saratoga Eyecare for any services and/or treatments furnished to you by this establishment. Understand that you are financially responsible for any non-covered services, treatments, and/or balances. Co-payment is expected at the time of service.

Our office is committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. To achieve this goal, we need your assistance and your understanding of our payment policy. We participate in select medical insurance plans. We will gladly bill your insurance company as a courtesy to you. Filing the claim on your behalf does not guarantee payment. If an open balance is not collected and goes into default, you will be responsible for all collection agency fees and contingent legal costs.

You request that payment of authorized Medigap or supplemental benefits be made on your behalf to Old Saratoga Eyecare for any services furnished to you by this establishment. You also authorize any holder of medical information about you to release to the Medigap or supplemental insurer any information required to process and determine these benefits payable for related services.

REFERRAL WAIVER: Understand that if you request and receive treatment from Old Saratoga Eyecare without providing the required referral form and/or insurance identification card(s), that you shall be personally responsible for any charges related to this and any future office visits or for services provided to you and/or your dependents.

All patients that do not have insurance are required to pay the full amount of their visit at the time of service. If you are making an appointment for your child, please send the person bringing your child with payment, or you may make arrangements with us to keep a credit card on file for the appointment.

MEDICARE LIFETIME SIGNATURE ON FILE AND AUTHORIZATION: (If applicable): You certify that the information given by you to apply for payment under Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information about you to be released to the Social Security Administration and/or its carriers any information required to process your medical claims. You request that payment of authorized benefits be made on your behalf to Old Saratoga Eyecare for services provided to you during the period you are under the care of this establishment.

CONTACT LENSES: Contact lenses are medical devices regulated by the FDA. Your Optometrist is required by law to evaluate the health of your eyes and the fit of your contacts every year to determine the best prescription for your eyes. For this service, contact lens patients will be charged a contact lens fitting and evaluation fee. Most vision and insurance plans require that this be charged separately from the exam. Many insurances do not cover this fee. When your contact lens prescription is finalized, you will be provided with a copy for your records.

GLASSES PRESCRIPTIONS: Prescription eyeglasses are medical devices regulated by the FDA. Your Optometrist is required to evaluate the health of your eyes and perform a refractive eye examination to determine these results. For this service, the patient will be charged an office visit fee and a refraction fee. Most vision insurance plans will cover these with your exam copay, but not all medical insurance plans do. If medical insurance does not cover the refraction fee the patient will be responsible for those charges to have the results of the refraction. When your eyeglass prescription is finalized, you will be provided with a copy for your records that will be valid for a period of 24 months from the date of service.

We reserve the right to charge a $50.00 fee for any appointment that is not cancelled at least 24 hours in advance.

A $20.00 fee will be added to your account for all returned checks in addition to the amount of your check and bank charges.

CONSENT/REQUEST FOR TREATMENT: I hereby voluntarily request and consent to treatment of myself or noted dependent by Old Saratoga Eyecare.

_____ _____

Signature of Patient / Parent or Legal Guardian Date

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