Mudgil Eye Associates, P.C.
610-429-3004
795 E. Marshall St., Ste. 103
West Chester, PA 19380

Consent to Treat, Assignment of Benefits & Privacy Form

Thank you for choosing Mudgil Eye Associates, P.C. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

1. Consent for Treatment

By signing this form I consent to and authorize my eye care provider to treat me. I understand this could include lab tests, x-rays, education or other diagnostic tests. I understand that my provider is available to explain the treatment and I have the right to refuse treatment.

2. Professional Service Insurance Release & Assignment of Benefits

I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my dependents by Mudgil Eye Associates, P.C. I also authorize payment of benefits directly to Mudgil Eye Associates, P.C., for services provided to my dependents or me. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered. (A photocopy of this authorization shall be considered valid.

3. Insurance

We participate in many insurance plans. If you are not insured by a plan we do business with or do not have an up- to-date insurance card, payment in full is expected at each visit. When you provide us with current and complete information, we bill primary and secondary insurances. Please contact your insurances company with any questions you may have regarding your coverage.

4. Referral

I understand that if my insurance requires a referral from my Primary Care Provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, it will be my responsibility to contact my Primary Care Provider's office the same day and obtain the necessary referral, dated for the date of the service. I also accept full financial responsibility for all charges incurred for services received on the day of service, if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

5. Payment

I accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card. There will be $15 processing fee if copay and/or deductible has to be billed and is not paid at the time of service. I also understand there will be an additional $25 processing fee for collection accounts and bounced checks for each date of service.

6. Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is Refraction, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge your refraction fee separately from your exam. Payment for these services must be paid at the time of your visit.

7. Contacts

Contact lens "fitting" is not included in a complete eye exam; it is a separate procedure with an additional charge. Payment for the "fitting" will be expected at the time of the service. The fitting is to determine the best contact lens for your eye 's curvature. This cannot be done on the same day as the comprehensive eye exam. To determine the health of your eyes, please schedule your comprehensive eye exam prior to the fitting.

8. Patient Authorization

I authorize Mudgil Eye Associates, P.C. to send copies of my records to other physicians as needed for continuity of care. I understand this is a group practice and other eye doctors may be involved in my care. I agree and understand that a copy of my medical records including AIDS, HIV behavioral health service, psychiatric care and treatment for alcohol or drug us will be included as part of my health information. I also agree that Mudgil Eye Associates, PC can release my medical records to accrediting or regulatory agencies, if those agencies request my records and if the law allows these agencies to see my records.

9. Authorization to Communicate Private Health Information

I authorize Mudgil Eye Associates to leave messages on my answering machine, voicemail or with individuals who answer the phone

numbers provided on the PATIENT REGISTRATION FORM.

Mudgil Eye Associates will share private health information with family or others when we feel it's in the patient's best interest to share appointment or eye care information. This means we will answer family questions, and confirm appointment information if the inquiry is made on behalf of the patient. If you do not agree with our policy, please provide the names of individuals who may answer your phone, with whom we should *not* share information:

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10. Patient's Right to Privacy

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have on HIPAA Notice of Privacy Practices on display in the reception area. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know reason for treatment, payment, and/or health care operations. If we were to disclose your information for any other reason, we would first need your written approval. A printed copy of the HIPAA notice will be provided upon request.

By signing below, I attest I have read the above and authorize Mudgil Eye Associates, P.C. to treat, bill and share my medical information as discussed above.

Signature of **Patient** / **Parent or Guardian** (if minor)

X_____

Patient or Guardian (if minor) **Name**_____**Date**_____

Relationship to Patient_____**(for minor)**