Valley Eye Group

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Bethlehem, PA 18015
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www.valleyeyegroup.com

PRACTICE POLICIES ACKNOWLEDGEMENT AND PATIENT CONSENT

Patient's Name: _____

- ✓ **INSURANCE SUBMISSION: A copy of your insurance cards is required** if you would like our office to submit for services rendered. Please remember that you are responsible for all deductible, co -pay and non- covered service amounts. Please see our complete financial policy for details

By signing below, you authorize Valley Eye Group PC to submit a claim to your insurance company or its intermediaries for all services rendered. Any information needed by my insurance company to make payment directly to Valley EyeGroup PC is authorized.

- ✓ **A COPY OF OUR PATIENT HIPPA PRIVACY POLICY:** is attached and available on our website. Please review this policy. A copy is available upon request.

- ✓ **OUR PATIENT FINANCIAL POLICY:** is attached and available on our website. Please review this policy and maintain a copy for yourrecords.

- ✓ **CREDIT CARD PAYMENT VIA ONLINE OR TELEPHONE:** We accept all major credit cards, cash, check, and Care Credit for the convenience to our patients to pay outstanding balances. You may authorize a credit card transaction over the phone or online at https://www.valleyeyegroup.com and click Pay Online at the top of the page.

- ✓ **RELEASE OF MEDICAL RECORDS:** We will be happy to mail or fax a copy of your medical record to your doctor on presentation of a signed release. If you require a copy for personal use, legal documentation, or disability, a record copying fee will be calculated according to PA law. A signed record release form and pre-payment will be required before any records will be supplied.

- ✓ **WORKMAN'S COMPENSATION PATIENTS:** Your employer may request information regarding your condition if you are being treated for a workmen's compensation injury. This information is provided to the Insurance carrier by law.

- ✓ **Communication Consent:** Please indicate how we can communicate protected health information. Please indicate telephone numbers we can use to contact you and who we are authorized to leave information with. Valley Eye Group will not release PHI without your expressed permission.

Phone number:_____ (home/office/cell) Leave message: (Yes / No)

Phone number:_____(home/office/ cell) Leave message: (Yes / No)

Authorized people to release PHI:

Name: _____Relationship:_____Phone: _____

Name: _____Relationship:_____Phone: _____

By my signature, I acknowledge that I have read, understand, and agree to the Practice Policies and Procedures of Valley Eye Group as defined in this document and the supporting documents that I received.

Patient or Legal Representative Signature:_____Date:_____

(January 2022)