Eye Physicians
of the East Bay
Medical Corporation
Diplomates, American Board of Ophthalmology

PATIENT INFORMATION

Assignment of Benefits I authorize Eye Physicians of the East Bay to bill my insurance for all services rendered in order to collect on any payments issued on my behalf. Furthermore, I agree to have any medical records copied and sent to my insurance company to facilitate claim payment and processing. This assignment may be copied and used the same as an original document. By initialing below, I acknowledge that all information is true and that I am compliant with the assignment of benefits. _____ **(Initial)**

HIPAA-Patient Privacy Act * I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by initialing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company). I further acknowledge that a copy of the current notice will be made available to me upon request, and I will be offered a copy of any amended notice of Privacy Practices at each appointment._____ **(Initial)**

Financial Policy We would like to thank you for choosing Eye Physicians of the East Bay as your healthcare provider. Our office is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For our Patients with Medical Insurance We participate in most major health plans. We contract with two HMO's (Hill Physicians and Affinity Medical Group) two vision plan (Vision Service Plan (VSP) and Medical Eye Services (MES) as well as many PPO's, and government agencies including Medicare and Medicaid. Our billing department will submit claims for all covered services rendered to a patient who is member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier is paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Non-paid claims resulting from lack of patient follow up will become the patient's responsibility.

Your insurance may require you to obtain an authorization or referral from your primary care physician or the insurance company directly. This is common among the majority of HMO plans and it is the patient's responsibility to obtain prior to being seen. This is a requirement set by your insurance and we may need to reschedule your appointment if the proper documents are not obtained prior to your scheduled appointment.

Co-payments: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and local law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks or the following credit cards: Visa, MasterCard, American Express, Discover and ATM transactions. If you do not have your co-payment you will be subject to a $15.00 service fee.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting all of your insurance's responsibilities, will be billed to you.

Non-Covered Services: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility

For our Patients with No Medical Insurance: If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Treatment of Minors: Patients under the age of eighteen should be accompanied by a parent. The parent or guardian of record with the minors chart will be responsible for payment of services. In rare cases, when a minor comes unaccompanied by a parent or guardian, the minor must have written consent from the parent of record, authorizing treatment as well as payment for services rendered.

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I have read and understand the financial policy of Eye Physicians of the East Bay and assume responsibility for payment of all services and materials.

Signature_____Date_____

INFORMED CONSENT FOR DILATING DROPS

In the course of your care, it is important for your doctor to evaluate your retina with a dilated exam. Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about driving following your appointment you may wish to make alternative transportation arrangements. The majority of patients do drive after a dilated exam with assistance of temporary sunglasses, which our office provides following the exam.

I authorize doctors and/or assistants of Eye Physicians of the East Bay as may be designated by him/her to administer dilating eye drops.

Signature _____Date _____

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Phone 510-893-4318
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Phone 925-283-8400
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