ANH NGUYEN
OPHTHALMOLOGY

HIPAA release of Private Health Information
I hereby authorize the release of any private information (PHI) obtained in the course of my registration, interview, examination and treatment, necessary to file or appeal any claim with my insurance carrier(s) or deemed necessary pursuant to State of Federal Law, statue of regulation. I acknowledge that if I wish to have any individual or entity restricted from access to my PHI, I will notify the office in writing.

Assignment of Insurance Benefits & Agreement to Pay Balance Due
I hereby authorize my insurance carrier(s) to directly pay Anh Nguyen Ophthalmology any medical/surgical benefits otherwise payable to me by my insurance carrier for services as rendered. I also accept responsibility for paying any monies not paid by my insurance carrier non-covered services for a balance due to Anh Nguyen Ophthalmology (including copays, deductibles, co-insurances and other carrier for a balance which the carrier fails to consider, except that dollar amount which is limited by the participating provider agreement between Anh Nguyen Ophthalmology and my insurance carrier(s).
I also agree to pay and not bill my insurance carriers for any claim that is past timely filing because I did not present my correct insurance card(s) to the office before the timely filing deadline lapsed.

Participation, Pre-Authorization, Referrals
I understand that I am responsible for contacting my insurance carrier(s) to confirm Anh Nguyen Ophthalmology participates with my insurance carrier(s) and that I am eligible to benefits on or before the date my visit(s) takes place.

Vision Plans
I understand this practice does not accept all vision plans (only a select few) and it is my responsibility to check eligibility. If any medical issues are detected or need to be treated during the routine visit, I understand this is subject to my medical insurance. I agree to pay any dollar amount denied or applied to my deductible/out of network pricing by my insurance (whether medical or vision).

Responsible Party Signature _____ Print Name _____

Date _____

Missed Appointment and Collections
I recognize that Anh Nguyen Ophthalmology reserves the right to charge me for missed appointments and appointments that are cancelled with less than 24hrs notice in the amount of ($50.00).

If at any time I have a balance due which is more than 90 days old, I understand that my account may be referred to an attorney for collection without notice. If my account is sent to an attorney for collection, I hereby agree to pay attorney fees in the amount of 35% of the principal amount owed and all collections costs incurred while collecting my unpaid debt. In addition, interest will be charged at the rate of 24% per (2% per month).

A copy of my signature to this agreement is as valid as the original.

Responsible Party Signature _____ Print Name _____

Date _____

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