# Dr. Michael Raff / Brockport Optometry, P.C.

## *RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORMCONSENT TO PROVIDE TREATMENT*

I, _____, have had the opportunity to review the Notice of Privacy Practices of the optometry office of Michael L. Raff, OD and Brockport Optometry, PC and have had the opportunity to obtain a copy of such notice.

I hereby provide my consent to Michael L. Raff, OD and his staff to provide medical care within the limits allowed under the laws of the State of New York and consistent with the standards of care within the community. I also consent to the use of my health care information to allow for treatment, payment and health care operations related to my care.

Patient/Responsible party signature_____ Date ____/____/____

## Office Financial Procedures

**** Please initial each line and sign at the bottom of this document.***

____ Insurance payment information is received from your insurance company by my staff. *Insurance does not guarantee the accuracy* of the information given to us on the phone or through the internet. You, as the insured are ultimately the responsible party and need to be aware of what your coverage is. Please take the time to call your carrier so you can provide us with accurate information.

____We receive an explanation of benefit (EOB) notice from your insurance company with their payment. You may receive a bill for an undercharged payment once we receive the insurance companies' explanation of benefit (EOB) notice sent to us.

____Procedures such as contact lens fitting or re-evaluation, or ocular imaging are often not covered benefits from insurance companies. They often qualify for reimbursement through a health savings account.

____Fees are due on the day services are rendered or a $10.00 billing fee will be applied. If you have a deductible for your insurance plan, you must meet that in full. If you are committed to optometric care and have financial difficulties, we will be happy to work out a payment plan.

____If you are unable to keep an appointment, we ask that you give the office at least 24 hours notice. If you have an appointment on a Monday, we ask that you call the office no later than the prior Thursday. If you do not contact us within that time frame, you will be charged with a $30.00 broken appointment fee.

____Please inform our clerical staff of any changes in insurance information.

Patient/Responsible party signature_____ Date ____/____/____