CHECK IN/HIPPA/RELEASE OF INFORMATION
PLEASE READ & SIGN BELOW

Patient Name (print):_____

Authorization:

I authorize the release of medical information about me to my insurance carrier(s) for the determination of benefits payable for services rendered and optical goods supplied by Broadway Eyecare Center. I request that payment of authorized insurance benefits for any services rendered to me be made on my behalf to Drs. Schnibbe & Connolly.

I understand that I am responsible for charges not paid by the insurance carrier(s).

Consent of Treatment:

I hereby grant MY authorization and consent for medical treatment and procedures for myself and certify that no guarantee or assurance has been made as to the results which may be obtained.

Insurance Billing:

BROADWAY EYECARE CENTER is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Our doctors are trained to diagnose and treat most ocular diseases.

As a courtesy to our patients we are happy to file with your insurance company.

NOTE: The patient is responsible for any co-pays and/ or deductibles which your insurance requires.

- **Routine Vision Exams** will be filed with a patient's ***vision insurance*** if you have any. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), Hyperopia (far-sightedness), astigmatism and presbyopia.
- **Medical Exams** will be filed with a patient's ***medical insurance*** if a medical diagnosis is determined by the doctor (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, dry eye, etc.) the patient's exam is no longer routine, but medical. We request a copy of your medical card in your records for these reasons.

I have read and understand when my ***Vision insurance*** will be billed and when my ***Medical insurance*** will be billed by Broadway Eyecare Center.

I, _____, have read and understand all of the above information.

_____ _____ _____

Signature of patient or Guarantor Relationship if not patient **Date**

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I, _____, have been presented a copy of the **HIPPA** privacy act. I have read it and understand the content. I know that at any time I can request my own personal copy of the form.

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I, _____, authorize **Broadway Eyecare Center**, doctors, and staff; to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations.

_____ _____

(Name of person(s) or doctor's office) Address/Phone number

(You may revoke this right at any time)