Robert M. Scharf, M.D.

HIPAA and FINANCIAL ACKNOWLEDGEMENT

I, _____ (patient), acknowledge that I have received or been offered a copy of Robert M. Scharf, M.D.'s (the practice's) Notice Regarding Privacy of Personal Health Information (HIPAA), Version 6-19-2016.

AND

FINANCIAL ASSIGNMENT AND RELEASE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payment for services not covered by your insurance plan is due at the time of service. We accept checks (Valid Driver's License Required), cash, money orders, and debit cards. MasterCard, Visa, Discover and American Express are also welcome. We will be happy to file your insurance if we are listed as a "Participating Provider" of your plan. You must realize, however, that:

- Your insurance is a contract between you, the employer and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- We will file your insurance on plans with which we participate only if we have a current copy of your insurance card and all pertinent information required for filing claims.
- If we are unable to verify benefits for a same day procedure, you will be asked to self-pay or reschedule. If you choose to self-pay, we will file for the procedure and upon receipt of the insurance explanation of benefits, if a credit balance exists, we will refund you within 15 business days.
- **I understand that I am financially responsible for "non-covered benefits," such as being measured for new glasses. Some plans include glasses measurements as a covered service. Others do not. If you ask for this service and your plan does not cover it, you will be responsible for payment for that service even if the Explanation of Benefits (EOB) states that you are not responsible.**

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may effect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

1. I hereby authorize payment directly to **Robert M. Scharf, M.D.** all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred, including refraction, specialized testing and all other services rendered on my behalf or for my dependents, whether or not these services are paid for by insurance.

2. I authorize **Robert M. Scharf, M.D.** and/or any other provider or supplier in the office of **Robert M. Scharf, M.D.** to release any information required to secure the payments of benefits or to provide for necessary medical services for me or my dependents.

3. I authorize the use of my signature on all insurance submissions.

SIGNED _____ Date _____

PATIENT UPDATE INFORMATION FORM

Please check the appropriate boxes and complete this form to update your Protected Health Information (PHI). Without the boxes checked and your signature, we cannot release any of your PHI.

Yes ❑ No ❑ Personal information
Yes ❑ No ❑ If you want a summary of your exam sent to you
Yes ❑ No ❑ If you want a summary of your exam sent to one or more of your physicians
Yes ❑ No ❑ If you want us to release your glasses specs to a third party
Yes ❑ No ❑ If you want us to release your contact lens specs to a third party

Name _____ Date _____
Address _____ City _____ ST __ ZIP _____
Phone Home _____ Work _____ Mobile _____

If you want an exam summary sent to you by email, enter your email address here _____. Otherwise, it will be sent by regular mail.

If you want your exam summary released to a physician(s), enter the physician(s) names below.

_____
_____
_____
_____

SIGNATURE _____
Date _____
Witness _____

ROBERT M. SCHARF, M.D.
OPHTHALMOLOGY

REFRACTION POLICY - MEASUREMENT FOR GLASSES

A refraction is the process of determining the best possible vision of your eyes, the eye's refractive error and the need for corrective spectacles or contacts. If you have blurred vision from any cause, a refraction is required before the evaluation of the health of your eye can be determined. It is an essential part of an eye examination, but it is NOT a covered service by Medicare and some insurance policies. Our office fee for a refraction is $40 and this fee is collected in addition to the patient's co-pay.

ACKNOWLEDGEMENT

I have read the above information and I understand that the refraction may not be a covered benefit service. I accept full financial responsibility for the cost of this service. The co-pay is separate from, and not included in, the refraction fee.

✔_____ _____

Patient Signature (Parent for minor) Date

_____

Print Name

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