Lakeshore Vision Centers ,LTD
Insurance and Patient Authorizations and HIPAA Compliance Acknowledgement of Receipt
Privacy Officer: Dayna Pekarek
Effective Date: 2/11/2022

1021 Jefferson Street
Algoma, WI 54201
(920) 487-2020

1217 Ellis Street
Kewaunee, WI 54216
(920) 388-2020

Patient Name:_____ Patient Date of Birth:_____

Identification of Communication Disclosure for Family Members/Friends/Caregivers

I authorize communication with the following person(s) regarding my health information and/or information related to my care. These communications will be when the identified person(s) accompany me on my clinic visit or communicate on my behalf.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

I understand that the release of my detailed medical records requires a specific authorization form signed by myself.

This disclosure form is in effect until I change or revoke it. Only I can change who is named on this form to receive my health information. At the time of change or revocation, a new form will be completed.

I acknowledge that I have been offered a copy of the Lakeshore Vision Centers, LTD Notice of Privacy Practices.

By signing this form, I understand and agree with the content.

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Signature of Patient or Legal Representative:_____

Date:_____Relationship:_____

PATIENT RESPONSIBILITY FORM

- **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
    - I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
    - If the patient is a minor, as the patient's guardian, I am ultimately responsible for payment of their treatment and care, even if I am not the carrier of their insurance policy.
    - Co-payments are due at time of service.
    - If I have insurance, Lakeshore Vision Centers, LTD will bill my insurance for me. However, I am required to provide correct and updated insurance information at every visit.
    - In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - The refraction is not considered a covered benefit by Medicare. The refraction charge must be paid by the patient unless covered under a vision plan. The refraction is the part of the exam in which the doctor determines your need for prescription glasses using numerous optical lenses.
    - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
    - I may incur and, therefore, am responsible for payment of additional charges if applicable. These charges may include:
        - A monthly late fee of 1.00% charged on accounts that are 90 days past due
        - $35 charge for returned checks

- **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

  I hereby authorize and direct payment of my medical benefits to Lakeshore Vision Centers, LTD on my behalf for any services rendered to me by the providers.

- **AUTHORIZATION TO RELEASE RECORDS**

  I hereby authorize Lakeshore Vision Centers. LTD to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services, as well as information required for precertification, authorization or referral to other medical providers.

- **MEDICARE REQUEST FOR PAYMENT**

  I request payment of authorized Medicare benefits to me or on my behalf for any services furnished by Lakeshore Vision Centers. LTD. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative, or Responsible Party Date