Vision Source
SIGNATURE EYE CARE

TAMMY HOLSCLAW-JONES, OD
BROOKE JONES-CANNON, OD

******PLEASE READ CAREFULLY BEFORE SIGNING******

Financial Responsibility: I understand that I, __________, am financially responsible for all services rendered to me at the time of treatment unless prior arrangements have been discussed and confirmed. **I accept full responsibility for payment of any services which are not covered under my insurance policy. I also understand that even with vision insurance it may be necessary to file certain procedures under my medical insurance, thus rendering the possibility of two separate copays for which I am responsible at the time of service.** I agree to pay any collection fees, court costs, and/or attorney fees should negligence of charges lead to necessary legal actions in efforts to collect delinquent reimbursements for services I received.

Release of Medical Records: I give permission to Dr. Tammy Holsclaw-Jones and her staff to disclose any or all parts of my medical records and/or financial ledgers to my insurance companies, third party co-managing physicians rendering treatment on my behalf, my attorney (if liability related), or employer and their workman's compensation carrier should a job related injury occur.

HIPPA Privacy Policy: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan, and direct my treatment and followup among the multiple health care providers who may be involved in that treatment both directly and/or indirectly. 2) Obtain payment from third-third party payers. 3) Conduct normal health care operations such as quality assessments and physical certifications. I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment, and healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time to the extent that you have taken action relying on this consent.

Patient Full Name: __________

Relationship to Patient (if patient is under the age of 18): __________

Date: ____________________

HIPPA Privacy Authorization:

☐ I **DO** authorize Dr. Tammy Holsclaw-Jones &/or her office personnel to use, disclose, &/or release my protected health information to the following persons as a trusted personal representative of myself and my medical records.

☐ I **DO NOT** authorize Dr. Tammy Holsclaw-Jones &/or her office personnel to use, disclose, &/or release my protected health information to anyone claiming to be a trusted personal representative of myself and my medical records.

1. Name of trusted person __________ Relationship to patient __________ Phone # __________

2. Name of trusted person __________ Relationship to patient __________ Phone # __________

______________________________ ____________________

Client Signature Date