Vision Source
Saxonburg Family Eye Care, LLC
324 Main Street, P. O. Box 500
Saxonburg, PA 16056

SIGNATURE ON FILE

_____I request that payment of authorized insurance benefits be made on my behalf to Saxonburg Family Eye Care for services furnished me by Dr. Amy Peterson, Dr. Jeffrey Peterson, and/or Saxonburg Family Eye Care. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

_____ I understand that there are certain procedures that are covered by my insurance but are subject to deductibles and co-payments. I also understand that there are other procedures that have been recommended by my doctor that are not covered by my insurance. I have been educated on the specific non-covered procedures and understand that I am responsible for payment.

MEDICARE SIGNATURE ON FILE

_____I request that payment of authorized Medicare benefits be made on my behalf to Saxonburg Family Eye Care for services furnished me by Dr. Amy Peterson, Dr. Jeffrey Peterson, and/or Saxonburg Family Eye Care. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Saxonburg Family Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Saxonburg Family Eye Care, LLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that

____ I was given the opportunity to read, have read or had explained to me Saxonburg Family Eye Care LLC's Notice of Privacy Practice prior to any services offered.
____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Saxonburg Family Eye Care, LLC to release my personal health information to the following individuals:

_____ Relationship _____

_____ Relationship _____

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

____ I authorize the use of standard email, despite the known risk involved.
____ I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY

Patient Name _____

Signature _____ Date _____

Authorized Agent _____ Relationship _____