CRAIG A. CASSEY, O.D., P.C. & ASSOCIATES
<u>Statement of Patient Financial Responsibility</u>

Patient Name: ____ DOB: ____________________

Craig A. Cassey, O.D., P.C., & Associates appreciate the confidence you have shown in choosing us to provide your eye health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Craig A. Cassey, O.D., P.C., & Associates for providing eye care services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Craig A. Cassey, O.D., P.C., & Associates, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ________________________

Guarantor Signature ____ Date ________________________
(If guarantor is not the patient)

<u>Insurance Information</u>

Insurance Co: _____________________________ Policy No.:___________________________________

Insured's Name: ____________________________ Relationship to Patient: ___________________________

<u>HIPAA Consent for Treatment and Authorization to Release Information</u>

In accordance with federal HIPAA regulations we are required to release information to your primary doctor (for HMO plans) and/or to your insurance company. Our office will only release information to individuals specifically designated by our patients. If you wish to designate any person(s) to access your information please list them below:

Name:___________________________________ Relationship: ____________________________

Name: ___________________________________ Relationship: ____________________________

Do we have permission to leave voicemail messages? Yes _____ No______

Limited health information may be released by fax or email with a verbal release (social security number may be required to verify identity). Your signature below acknowledges that you are allowing Dr. Cassey and his designees to disclose and/or discuss any and all medical and financial information in our possession with any individuals listed above. This authorization will remain in effect until termination with current insurance or, for minors, until they reach age of majority.

Signature: ____ Date: __________________________
(Minors must have parent/legal guardian)

Emergency Contact: ______________________________ Date: __________________________