

DAOUD EYE CARE
Milad M. Daoud, O.D.
9173 Rt 30 Irwin, PA 15642 / 355 Lincoln Highway N. Versailles, PA 15137

We welcome you to our practice and we ask that you kindly complete or correct all information on this form.

Acknowledgement of Receipt of this Notice:

This practice is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Daoud Eye Care

Name of Patient (please print): _____

Signature of patient or authorized representative

Medical Insurance Policy:

As part of our services at this practice we are happy to assist patients in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

- 1) The legal obligations of your insurance provider is between yourself and your provider, not between this practice and your provider.
- 2) When your insurance provider(s) have settled your plans covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility, or termination of coverages. Unpaid balances are the sole responsibility of the patient.
- 3) To keep the cost of records and collections down, any patient portion amounts on your order will be due at the time of service.
- 4) I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all of my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
- 5) I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.