HIPAA POLICIES & PAYMENT POLICIES

Acceptance of Eaton Vision Clinic's HIPPA Policies and Payment Policies

I authorize Eaton Vision Clinic to use and disclose protected health information about me or my dependents to carry out treatment, payment and health care operations as defined by Eaton Vision Clinic's full Notice of Privacy Practices (NPP). The NPP describes such uses and disclosures more completely. The full NPP was made available to me to review prior to signing this consent. I certify that the given information is correct to the best of my knowledge. I authorize Eaton Vision Clinic to release any personal health information including diagnosis and records of any treatment or examination rendered to me or my dependents to third party payers. I authorize and request my insurance company to pay directly to Eaton Vision Clinic.

I understand that my vision or medical insurance may pay less than the actual bill for services and I will be responsible for payment of additional or non-covered procedures for myself and my dependents. In the event my insurance company refuses payment, for any reason, I agree to be responsible for payment of all services rendered on my behalf and my dependents. A finance charge is added to unpaid balances at the rate of 1.5% per month (18% per annum).

PATIENT/GUARDIAN SIGNATURE: *DATE:*