

HIPAA Compliance Acknowledgment of Receipt & Signature on File

Date: _____

Patient Name: _____

**I acknowledge that I been shown and offered a copy of Optom Eye Care LLC
D.B.A. Great Lakes Optometry,
Notice of Privacy Practices.**

Patient/guardian/Parent Signature: _____

Date: _____

**Signature on File for Optom Eye Care LLC
D.B.A. Great Lakes Optometry**

I authorize Optom Eye Care LLC D.B.A. Great Lakes Optometry to use my name and release any information on any claims or documentation that relates to health insurance benefits due me and my dependents.

All billed balances need to be paid within 90 days of receiving an invoice. Any co-pays, co-insurance, deductible amounts, non-insurance balances, or other balances we can determine prior to the appointment are due by the end of your appointment. They may be sent to collections if an invoice is due past 90 days. There is a service charge for returned checks of \$45. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and final determination can only be made when the claim is processed.
There are no cancellations or returns on any custom-made orders including eyeglasses.

**I Agree to the Signature on File for Optom Eye Care LLC
D.B.A. Great Lakes Optometry:**

Patient/guardian/Parent Signature: _____

Date: _____

Medicare Beneficiary Notice

For your convenience, our office bills Medicare for your office visits and tests. Medicare reviews claims, and if approved reimburses 80% of the billed amount. The remaining 20% (the co-payment) is your responsibility. Medicare has a yearly deductible that takes effect each January. Medicare does not pay for refractive services. This is the part of the exam that determine your glasses prescription. Your portion for this test is \$40.00. Medicare does not cover glasses or contacts unless you have had cataract surgery. We do not bill Medicare for these services; however, we may have discounts available for glasses after cataract surgery. By signing below, I understand that I am responsible for the above mentioned non-covered service(s) and agree to receive the service.

Patient/guardian/Parent Signature: _____

Date: _____

Medicaid/UPHP Members

By signing, I understand that Dr. Thomas Chophonis is a non-participating Medicaid provider and I agree to pay out of pocket for all services and materials that would otherwise bill to Medicaid / UPHP. I fully understand that the amounts I pay are not reimbursable through my health care plan and I give up any right to appeal.

Patient/guardian/Parent Signature: _____

Date: _____