SEEN
FAMILY EYECARE

Dr. Fadee M Bittar, O.D.
19 Hidenwood Shopping Center,
Newport News, VA, 23606
(757) 324-3952
www.seenfamilyeyecare.com

SEEN FAMILY EYECARE - Our Financial and Insurance Policy

Thank you for choosing SEEN Family Eyecare for your eye and vision care!

Our goal is to provide you with the highest quality of vision and medical eye care services. We feel it is helpful and important that you understand our billing process. As a courtesy service to you, we will be filing your vision and/or medical insurance claim for any services provided to you or your dependents at our office. Please note that all information provided to you regarding your benefits are estimates based on the insurance data available at the date and time of service. All co-payments, deductibles or non-covered services remain your responsibility.

Each patient must complete the Patient Information Form and the insurance form, should you wish to use vision services. We must have this information completed before you see the doctor on your first visit.

METHODS of Payments: Full payment is required at time of service. You may choose to pay by check, cash or credit card. We offer prompt payment discount to patients with no insurance benefits.

Insurance: We will bill your insurance carrier. Please note that any unpaid balance or unpaid claims by your insurance will be your responsibility. Co-payments and or unpaid deductibles will be due at the time of service. If you are using your insurance benefits as "out of network", we will do our best to verify your eligibility and benefits. However, it is your responsibility to know the details of your insurance coverage.

Missed appointments: We make every effort to schedule patients at a time that is convenient for them to see the doctor as quickly as possible. At times, there can be a wait to see the doctor, for non-urgent visits. If you are unable to keep your scheduled visit, please notify our office as early as possible so that patients who are waiting to see the doctor may have the opportunity to get an appointment scheduled. We do ask for a 48-hour advanced cancellation, except in case of medical or family emergencies.

Contact Lense Fitting: The initial contact lens fitting exam fee covers all follow-up visits for up to a 3-month period from the initial exam date in order for the doctor to finalize your contact lens prescription. Any follow-up visits AFTER the 3-month period will incur a fee of $25.00 per additional visit.

Are you planning on using vision or medical insurance for this visit? YES ☐ NO ☐

I authorize the release of any information including the examination rendered to me or my dependents to the insurer or agency necessary to process the claims filed at this office. I authorize and request my insurance company to directly reimburse the doctor for services rendered on my behalf or the behalf of my dependents. I understand that SEEN Family Eyecare is filing the insurance claim as a courtesy to me and all financial information provided are estimates based on the insurance data available at the date of service. I acknowledge that co-payments, deductible or non-covered services remain my responsibility. I also understand that all professional services are non-refundable. I am also attesting that I received a physical copy of my prescription, if applicable to my visit.

Patient Acknowledgement: I have read and understood the financial policies as described above:

Patient NAME : _____ Date: _____

Patient signature (or legal guardian): _____

Make Every Patient Feel SEEN. *Genesis 16:13*

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HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT - CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information:
By signing this form, I give SEEN FAMILY EYECARE permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Seen Family Eyecare has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Seen Family Eyecare which describes how Seen Family Eyecare may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Seen Family Eyecare may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Seen Family Eyecare by contacting Seen Family Eyecare via email or go on our website.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Seen Family Eyecare be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting SEEN Family Eyecare at 19 Hidenwood Shopping Center, Newport News, VA, 23606. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Seen Family Eyecare may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing. References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

Medical Release Authorization: The Health Insurance Portability & Accountability Act of 1966 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential. The Doctors and Staff of Seen Family Eyecare may release information on my health to the following individuals or organizations:

Name: _____ Relationship/Organization: _____

Name: _____ Relationship/Organization: _____

Name: _____ Relationship/Organization: _____

_____ _____
Signature of patient or authorized representative Date

_____
Print name of patient