Hussey Eyecare

www.scotthusseyod.com

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PATIENT FINANCIAL RESPONSIBILITY

I authorize Hussey Eyecare to apply for benefits on my behalf for any services performed by him and staff. I agree and assign my benefits and request that all payments from my insurance plan(s) be made directly to the above provider, Hussey Eyecare. I agree to and assume responsibility of any unpaid balances not covered by my insurance plan(s), or to assume full responsibility for patient fees if I have no insurance coverage.

Patient Signature: ____ Date: _______________
If the patient is a minor, Parent or Guardian is required to sign above.

Responsible Party Signature (if different than above): ___________________________________

NOTICE OF PRIVACY PRACTIES

The law requires that Hussey Eyecare make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

□ I have read or had explained to me Hussey Eyecare Notice of Privacy Practice and agree to continue my care with Hussey Eyecare under said terms.

□ I was given the opportunity to read Notice of Privacy Practice and declined but wish to continue my care with Hussey Eyecare under said terms.

□ I consent to receive messages that pertain to Hussey Eyecare by email, text, or secure portal.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGINING IT VOLUNTARILY

Patient Signature: ____ Date: _______________
If you are signing as a personal representative of the patient, please indicate your relationship

Represenative: ___________________________________ Relationship to Patient: ____________