Dr. Robert Ramp, Optometrist
165 Hargraves Dr Ste M600
Austin, TX 78737
512-301-8664

HIPAA Compliance Patient Consent Form

The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

We are required by law to maintain the confidentiality of any health information that identifies you. Belterra Eyecare is committed to protecting patient privacy. This is an ethical and legal obligation we owe to our patients. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
By signing this form, I understand that:

- This practice has the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- Protected health information may be disclosed or used for treatment, payment, or healthcare purposes.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

May we discuss your medical information with ***any*** family member of your family?
YES NO
If *YES*, please name the members allowed:
____

This consent was signed by: ____
Printed Name-Patient or Responsible Party
__________________________________ ___/_____/______
Patient Signature or Responsible Party Date
____
Relationship to patient (if other than patient)

FINACIAL POLICY

We at Belterra eyecare are a proud team whose primary mission is to deliver the finest and most comprehensive vision care available today. In addition, your co-payment and/or deductibles are due at the time of service. To assist you, we accept cash, checks, all major credit cards and CareCredit. The amounts of payments are *estimates* only. We strive to be as accurate as possible. There are, However, occasions when service is more extensive than originally estimated. If this occurs, you will be informed of the changes as well as an explanation of the need for it.

REGARDING INSURANCE

As a courtesy to our patients, we will be happy to file your insurance. However, to avoid misunderstanding, please read carefully and understand the following:

1. It is your responsibility, as well, to be fully aware and knowledgeable about your insurance coverage (and inform us of any changes). This office is very knowledgeable about vision insurance in general. We cannot however, be experts on every individual policy. You should be aware that different insurance companies vary greatly in types of coverage they make available.
2. We ask that you view your insurance policy realistically. It is in your contract and it is therefore your responsivity to see that the claims are paid promptly. Please be aware that some of the services provided may be non-covered services and/or not considered reasonable or necessary under the policy your employer has selected.
3. Any balance left unpaid by insurance is yours to pay. This balance is required in full when you receive a statement from us.
4. Regarding insurance plans where we are participating providers, all co-payments and/or deductibles are due at the time of service. If a service is not covered, it is your financial responsibility.

Thank you for taking the time to read and understand our office policy. Our goal is to make your visit comfortable and pleasant, to be efficient with your time, and to communicate clearly with you. We believe that communication is key to excellence in eye care.
We are here to help you see!

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Printed Name-Patient or Responsible Party

____ ____________________

Patient Signature or Responsible Party Date

____ _____/_______/______