OFFICE POLICIES

1. **Payment at Time of Service**

   You are responsible for any co pays, co-insurance, deductible, and other non-covered services or materials the day services are rendered. If you are a self pay patient and/or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept cash, checks, MasterCard, Visa, American Express, and Discover cards. If you are being seen for any ongoing medical problem, co pays are due at each and every visit. If you foresee any payment problems please speak to our office manager prior to your appointment.

2. **Claim Filing**

   As a courtesy to our patients, we will file claims with your insurance company. We will do our best to accurately verify benefits for services and/or materials, however, benefits quoted by your insurance carrier **are not a guarantee of payment.** Should your Insurance deny a claim for any reason, you will be responsible for any remaining balances as directed by your insurance. When required by your insurance company, you are DIRECTLY responsible for obtaining referrals from your Primary Care physician.

3. **Cancellation Policy**

   We **require 24 hours notice** to cancel or reschedule an appointment. We understand that emergencies do come up. Please call our office as soon as possible if you cannot keep your appointment so that other patients in need of care can be seen. Any appointments not cancelled will result in a **$35 fee before rescheduling your next appointment.**

4. **Patient Billing and Collections**

   Patients that receive a statement from our office are expected to remit full payment upon receipt unless previous payment arrangements were made with our billing office. Patients in collections must make payment arrangements prior to scheduling another appointment with our office. **If you receive a billing statement that you do not understand, please contact the office where services were rendered.**

Date_____ Print Name_____

Sign Name_____

DR. DAVID J. MELLISH, OPTOMETRIC PHYSICIAN
MELLISH PROFESSIONAL CENTER
490-A NORTH BLACK HORSE PIKE
P.O. BOX 826
WILLIAMSTOWN, NJ 08094
TEL: (856) 728-1111 FAX: (856) 728-8132
www.eyezoneyecare.com
New Jersey License/Certification # 27OA00409300/27TO0000480

IN ACCORDANCE WITH FEDERAL REGULATIONS REGARDING PATIENTS PRIVACY, PLEASE READ AND SIGN THE FOLLOWING:

I _____ give permission to Dr. David Mellish and staff, to do the following:

Mail reminder cards of upcoming appointments.
Confirm appointments by phone
Leave messages on answering machine
Leave messages to call our office regarding healthcare
Release medical information requested by another treating physician or health institution

I also give permission to Dr. David Mellish and staff to request information from other physicians and/or institutions to assist in my ongoing treatment.

I also give permission to Dr. David Mellish and staff to speak to family members (i.e., spouse, parents, etc.) regarding plan of treatment or billing information.

_____ _____

Date Signature

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent. I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the rights to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name_____

Relationship to patient_____

Signature_____