## I direct and assign payment from my insurance company(ies) to Poole Eye Associates, PA. I understand that my policy is a contract between my insurance company, and I. I understand that I am responsible for any charges not covered by my insurance, copayments, and deductibles. Poole Eye Associates, PA. will not be held responsible for inaccurate information during the insurance verification process. The parent or legal guardian accompanying a minor will be held financially responsible for all the services provided by Poole Eye Associates, PA., and agree to all terms listed below.

**Financial Agreement**

**Terms of Agreement**

* I understand that all co-pay’s are due at the time of service.
* I understand that it is my responsibility to obtain any prior authorizations required by my insurance prior to date of service. It is my responsibility to understand, and comply with my insurance guidelines.
* I will notify Poole Eye Associates, PA. of any changes in my information, including demographic information, and any changes in insurance(s).
* I certify that I have insurance coverage as provided to Poole Eye Associates, PA. I hereby authorize the release of all information necessary to bill your insurance.
* I authorize the use of this signature on all insurance submissions.

**Consent for Use and Disclosure of Protected Health Information**

By signing below, you consent to the use, and disclosure of your protected health information for treatment, payment, and healthcare operations.

**Privacy and HIPAA (Health Insurance Portability and Accountability Act**

Poole Eye Associates, PA. is in full compliance with HIPAA regulations, and guidelines. A copy and disclosure of our privacy policy is published, and accessible to our patients.

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**Patient or Legal Guardian Signature Date**