Bayshore Ophthalmology, LLC
Privacy Practices and Financial Agreement

_____ _____
Name *(print)* Date

NOTICE OF PRIVACY PRACTICES: The complete document that states Bayshore Ophthalmology's Privacy Practices is posted for you to read in full. Please read it carefully. It explains our commitment to maintaining the privacy of your private health care information. I you would like a copy we will provide it to you.

DISCLOSURE OF PROTECTED HEALTH INFORMATION: I request that payment of authorized insurance benefits be made to me or on my behalf to BAYSHORE OPHTHALMOLOGY, LLC for any services furnished to me by Bayshore Ophthalmology. I authorize any holder of my medical information to release to my insurance company and its agents any related information. I hereby authorize my insurance company to furnish to Bayshore Ophthalmology information regarding my medical claims.

Please list persons to whom we can release your medical information:

_____ _____

DISCLOSURE OF OWNERSHIP OF BAYSHORE OPHTHALMOLOGY, LLC: Public Law of the State of New Jersey and the Board of Medical Examiners mandates that we inform patients of any significant financial interest held in a health care service. Accordingly, we would like to inform you that Dr. Surekha Collur owns Bayshore Ophthalmology, LLC. You may purchase your eyeglasses a a facility of your choice. A listing of alternate providers can be found in the classified section of the telephone directory under the appropriate heading.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Bayshore Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Bayshore Ophthalmology for payment. If an account is sent to an attorney or a collection agency, I agree to pay collection expenses of up to $50 or 20%, of the total balance, whichever is greater, upon placement with an attorney or collection agency because of an unpaid balance on my account. I understand and agree that if my account is delinquent, any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Bayshore Ophthalmology. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Bayshore Ophthalmology.

NO SHOW/LATE CANCELLATION FEE: A fee of $25 may be added to your account should you miss an appointment or fail to cancel an appointment more than 24 hours prior to scheduled time.

RETURNED CHECK FEE: I also understand that if one of my checks are returned to Bayshore Ophthalmology for "insufficient funds" I will have to pay a returned check fee of $35 which will be added to my bill. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____
Signature of Authorized Party Date