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 available for you to read in full. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice. By signing this form you understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy allowed by law
- The patient has a right to revoke this consent in writing at any time

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 Bayshore Ophthalmology information regarding my medical claims.

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

1._____ **2.**_____
Name/Relationship Name/Relationship

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 at 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, are 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 $50 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 is 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.

ADDITIONAL TESTING: If our doctors see something in your exam that may be a cause of concern, they look further into the possible issue so that they can treat or diagnose you properly. Therefore, you may come in for what you feel is a regular or routine exam, but you may need additional tests. These ***tests are only billable to your medical insurance*** company, so if you came to us using your routine vision insurance (VSP or EyeMed), these tests will not be covered by this insurance. In addition, some medical insurances may either ***require a referral, an additional co-pay or the charge may be applied to your deductible.*** By signing below, you acknowledge the statement above and understand that you may possibly owe additional fees if you have testing performed by the doctor. ***If you do not want any testing and want the exam only, please notify the receptionist on arrival.*** Understand that without testing, a complete diagnosis or treatment plan may not be able to be made and you may require an additional office visit.

_____ _____
Signature of Authorized Party Date