SKYVISION
CENTERS

HIPAA Authorization and Privacy Practices

I hereby make, constitute, and appoint SkyVision Centers to execute on my behalf and sign my name on any and all medical health insurance forms relating to medical treatment rendered by SkyVision Centers, including the power to direct payment of any such insurance benefits directly to SkyVision Centers.

I understand that this is a lifetime medical authorization request and that payment of medical benefits be made either to me or to SkyVision Centers on my behalf for any services rendered. I also authorize release to the agency that regulates medical fees and payments, and its agents, any medical information needed to determine the benefits payable for related services.

Unless SkyVision Centers obtains payment directly from my insurance company or any other third party payer program under which i am covered, I am responsible for paying the full amount charged for the services. Should SkyVision Centers receive direct payment, I am still responsible for any deductible or co-payment due.

Notice of Refraction Charges

I understand that Medicare and other insurance carriers may not cover refraction exams for glasses prescriptions. If my eye doctor feels that I need a new prescription, I understand a refraction needs to be performed and that a fee of $35 for this service is my responsibility.

IN ORDER TO KEEP THE REFRACTION CURRENT, THE POLICY IS TO PERFORM A REFRACTION AT LEAST EVERY TWO (2) YEARS OR IF THERE IS A CHANGE IN VISION.

I acknowledge that I have been notified of SkyVision Centers Patient's Rights to Privacy and Refraction Charges.

Patient / Agent / Guardian Signature Date