Mark D. Bennett, Optometrist
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13530 Northgate Estates Dr. Suite 200 Colorado Springs, CO 80921
Office 719.593.2333

Name:_____ Date of Birth:

HIPPAA Statement: WE RESPECT OUR OBLIGATION TO KEEP HEALTH INFORMATION PRIVATE. We are obligated by law to give you notice of our privacy practices. "I understand Spectrum Eye Care has a notice of privacy practices, which is available for my review if I wish. I acknowledge this notice has been offered." A copy of Notice of Privacy Practices policy is available upon request

Initial:

I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third-party payer and/or not paid to Spectrum Eye Care, P.C. For any reason within a time period deemed reasonable by Spectrum Eye Care, P.C,

Initial:

Payment is required at time of services. Any Insurance Co-Payment is due at time of service. Our office will be happy to provide you with a super bill for any insurance companies with which we are not under contact.

I understand that it is my responsibility to present adequate & timely insurance information to Spectrum Eye Care before services are rendered. I also understand that my insurance plan will not be billed for services if I cannot provide the correct information at time of service. This can result in any fees for service becoming my full responsibility.

Initial:

If an appointment is cancelled within 24 Hours of the scheduled time a fee may be charged for the lost appointment.

Initial:

Assignment of benefits *Financial agreement

I hereby give authorization for payment of insurance benefits to Spectrum Eye Care, P.C. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this health care provider to release all information necessary to secure the payment of benefits. It is not Spectrum Eye Care's responsibility to know if you have met your deductible. It is your responsibility to understand your insurance.

Initial:

Signature of Patient/Responsible Party

_____ Date:

Medical Release for family or friend

If you would like to authorize another person to be able to obtain your medical information, please list their name(s) and contact info below.

Name of Individual:_____Relationship_____Phone: