

WELCOME TO BROADWAY EYECARE

CHECK IN/HIPPA/RELEASE OF INFORMATION
PLEASE READ & SIGN BELOW

Patient Name (print): _____

Authorization:

I authorize the release of medical information about me to my insurance carrier(s) for the determination of benefits payable for services rendered and optical goods supplied by Broadway Eyecare Center. I request that payment of authorized insurance benefits for any services rendered to me be made on my behalf to Drs. Schnibbe & Connolly.

I understand that I am responsible for charges not paid by the insurance carrier(s).

Consent of Treatment:

I hereby grant MY authorization and consent for medical treatment and procedures for myself and certify that no guarantee or assurance has been made as to the results which may be obtained.

Insurance Billing:

BROADWAY EYECARE CENTER is committed to caring for our patient’s complete ocular health. Our patients will receive a COMPLETE EYE EXAM. Our doctors are trained to diagnose and treat most ocular diseases.

As a courtesy to our patients we are happy to file with your insurance company.

NOTE: The patient is responsible for any co-pays and/ or deductibles which your insurance requires.

- **Routine Vision Exams** will be filed with a patient’s **vision insurance** if you have any. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), Hyperopia (far-sightedness), astigmatism and presbyopia.
- **Medical Exams** will be filed with a patient’s **medical insurance** if a medical diagnosis is determined by the doctor (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, dry eye, etc.) the patient’s exam is no longer routine, but medical. We request a copy of your medical card in your records for these reasons.
- **HIPAA Privacy Act** *I have been offered a copy of the HIPPA Privacy Act. I know that at any time I can request my own copy of this form.

I authorize Broadway Eyecare Center, doctors, and staff; to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the required individuals or organizations.

Signature of patient or Guarantor

Date

