Belk Eye Clinic
& OPTICAL

Cypress Professional Park
12199 Hwy 49, Suite 100
Gulfport, MS 39503
Phone: 228-832-1832 Fax: 228-832-5115

Dr. Craig R. Belk
Optometrist

Dr. Paul M. Williston
Optometrist

NOTICE OF PRIVACY POLICIES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (*HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up care among the healthcare providers who may be involved in that treatment directly or indirectly.
*Process my insurance claim for services rendered and obtain payment from third-party payers.

I have received, read and understand the Notice of Privacy Policies containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Policies, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Policies.

Print Patient Name: _____

Patient/ Guardian Signature: _____

Relationship to Patient: _____

Date: _____

AGREEMENT OF PAYMENT

I, the undersigned, do hereby understand and agree that I am responsible for all charges to my account.

I am aware if I, or anyone in my household has an outstanding balance, Belk Eye Clinic can refuse service until balance is paid in full.

I further understand that all insurance claims are filed as a courtesy by Belk Eye Clinic with the insurance carrier that I provide to Belk Eye Clinic at the time of service.

I understand that Belk Eye Clinic will allow sixty (60) days for payment to be made by the insurance carrier at which time I may be held responsible for any unpaid portion of the balance.

If I am not covered by an insurance carrier, I agree that I am responsible for all charges at the time that services are rendered unless financial agreements have been made in advance.

Should my account become past due and is transferred to an attorney and/or collection agency, I understand that I will be responsible for all attorney, court and any other associated fees with the collection of the account.

_____ _____

Patient/ Responsible Party Signature Date