Dennis J. Schlader, O.D.
Jayme N. Wilhelm, O.D.
John W. Weihe, O.D.
Anna M. Dimmer, O.D.
Nickolas J. Huisman, O.D.

ACKNOWLEDGEMENT OF NOTICE OF PRIMARY PRACTICES

The law requires that Eye Associates of Iowa City, P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

______ I was given the opportunity to read, have read or had explained to me Eye Associates of Iowa City, P.C.'s Notice of Privacy Practice prior to any services offered.

I authorize Eye Associates of Iowa City, P.C. to release my personal health information to the following individuals:

Name: ___________________________________ Name: ____

VISION VS MEDICAL: WHICH INSURANCE IS USED

______ During the performance of a comprehensive eye examination, certain medical eye conditions may be revealed that deserve special attention. I understand that there are specific coverage limitations with my vision care plan and that Eye Associates of Iowa City contract with the vision care plan may not cover medical eye care services. In this event, my medical plan will be billed, and I understand I will be responsible for any applicable copays, cost-shares and/or deductibles. I also understand that Eye Associates of Iowa City will not neglect medical findings to bill my vision plan, as that would put Eye Associates of Iowa City in direct conflict with its ethical obligations to the Iowa State Board of Optometry.

ASSIGNMENT OF BENEFITS: INSURANCE

My right to payment for all procedures, tests, supplies, and technical/physician services including major medical benefits are hereby assigned to Eye Associates of Iowa City, P.C. This assignment covers all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance company does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Eye Associates of Iowa City, P.C.

NON-COVERED SERVICES: PATIENT RESPONSIBILITY

I understand that I am responsible for fees not covered or reimbursed by my insurance. These may include but are not limited to COPAYS, COST-SHARES OR DEDUCTIBLES. I agree, In the event of non-payment, to assume the costs of Interest, collection and legal action (If required).

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING VOLUNTARILY.

Patient PRINTED _____________________ Patient signature (18 yrs +)_________________ Date__________

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Patient Representative _________________________ Date_____________ Relationship_________________