PATIENT INFORMATION, MEDICAL RECORD RELEASE, AND HIPAA AUTHORIZATION
Dr. Don Robbins, Inc.

PATIENT NAME: _____
Suffix (Jr., III, etc.)

DOB: ____/____/____

RELEASE OF INFORMATION: Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information .

Name(s) of persons:

_____ Phone:(____)_____ Relationship:_____
_____ Phone: (____)_____ Relationship:_____
_____ Phone: (____)_____ Relationship:_____
_____ Phone: (____)_____ Relationship:_____

My signature below authorizes the release of medical information to my primary care or referring physician and to process insurance claims/applications, and prescriptions.

In compliance with HIPAA regulations, we are required to have confirmation that you have been offered a written copy of Dr. Don Robbins, Inc. Notice of Privacy Practices. My signature below indicates that I have been given an opportunity to review a copy of Dr. Don Robbins, Inc. Notice of Privacy Practices.

If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. Please do not hesitate to ask if you have any questions regarding the HIPAA regulations.

Patient Name: _____
(PLEASE PRINT)

_____ Date: _____
SIGN PATIENT/RESPONSIBLE PARTY

Additional Information:

1. Name of Pharmacy: _____
2. Spouse's Name & Employment: _____
3. Name of last Eye Doctor: _____

Dr. Don Robbins

FINANCIAL POLICY AGREEMENT (FPA)

Thank you for choosing Dr. Don Robbins to treat your eye condition(s). He is committed to excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA and the Patient Information Form (PIF) prior to receiving any medical care from us.

Please initial and then sign the following:

_____ 1. Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances and deductibles are to be paid in full at each visit. Your insurance policy is a contract between you and your insurance company. We accept cash, checks, major credit cards and **Care Credit.**

_____ 2. As a courtesy, Dr. Robbins' office will file claims to your insurance carrier(s). To accomplish this, you must provide all insurance policy information and changes to our office. If the insurance company(s) that you designate is incorrect, you will be responsible for payment of the visit. Your bill is your responsibility, whether or not your insurance company pays.

_____ 3. As a specialty physician, some insurance companies require that an authorization or referral be obtained prior to your visit. It is your responsibility to know if your insurance requires this and to obtain the referral/authorization. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

_____ 4. A $30.00 fee will be charged on all returned checks.

_____ 5. From time to time, you may ask us to complete various forms (such as disability forms) and/or write letters to other individuals. There is a $25.00 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 7 to 14 business days.

_____ 6. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to Dr. Don Robbins for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood the signing of this form does not release the patient's responsibility of paying any balance due after your insurance company has paid their portion. I authorize the release of any medical or other information necessary to process this claim.

By signing below, I acknowledge receipt of this FPA.

X_____ X_____Date ___/___/____

Signature of patient or responsible party Dr. Don Robbins, Representative