- **Assignment of Benefits** and what this means - By signing below you're giving your insurance company permission to pay NWE directly, as we submit claims on your behalf as a courtesy. I hereby instruct and direct the primary and supplemental insurance company(S) on file which I verified is correct and accurate upon check in for today's appointment. Insurance Company(s) to pay by check or direct deposit made out to: Northwest Eye Clinic, Ltd. Located in Des Plaines, IL for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assigner, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case, to determine these benefits or the benefits payable for related services. I authorize my doctor to initiate a complaint to the Insurance Commissioner on my behalf.
- **Northwest Eye Clinic Policy** By signing below I understand that my medical claims may not be covered in full by my insurance company and I will be responsible for any balance. Routine eye care, eyeglasses, contact lenses, refraction and routine examinations are not covered by medical insurance. If you are active with a skilled nursing facility at the time of service, your insurance will deny your claim and you will be held responsible. We do not accept any Medicaid plans. Medicaid portions will not be written off, therefore will be the patient’s responsibility. In the event I am an HMO patient and do not bring a referral for services provided by Northwest Eye Clinic, Ltd., I understand that I am responsible for any charges incurred. In event that I am HMO and have an approved and valid referral from my primary care provider, I understand this is not a guarantee of payment and I will be billed for any services not covered by my insurance company. In the event my account balance becomes 45 past due I understand there may be a late charge per billing cycle. Northwest Eye Clinic, Ltd. has financing and payment options at 0% financing available in the event payment cannot be promptly made, in the event financing or a payment agreement is made with Northwest Eye Clinic, Ltd. no late charges will apply. In the event my account is placed into collection Northwest Eye Clinic, Ltd. shall be entitled to recover all reasonable collection fees. Any request for medical records must be in writing, three to five days prior to receiving the records, charges for records may vary by size of chart. Your signature below certifies that the information above is correct and true to the best of my knowledge. I have read and understand both benefit and office policy.
- **Notice of Privacy Practice HIPAA Summary** this notice describes how medical information about you may be used and disclosed and how you can get access to this information. please review it carefully. our commitment here at northwest eye clinic, ltd. is to serve our customers with professionalism and care, being always sure to protect the privacy and security of all Protected Health Information. During your care it may be necessary to share information with other health care providers or business associates. The following are examples of instances where this information can and will be shared: To conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly. During treatment, we may find it necessary to acquire a laboratory analysis. Obtain

payment from third-party payers, Insurance Companies, and billing services. Conduct normal health care operations such as quality assessments and physician certifications. We at Northwest Eye Clinic, Ltd. are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law. If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at (847) 296-4020. I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my Protected Health Information. I have received and understood your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you may restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. Full notice attached

- **Credit Card Signature on File.** We understand that convenience is not often associated with today's health care environment. Our Practice not only focuses on excellent health care service but also how to provide service as cost and time effective as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments. We provide secured methods of accepting your payment at the time of treatment also keeping your credit card on file to handle any remaining balance after your insurance company's reimbursement. We will always get verbal consent from you prior to running any transaction. We will work with you in establishing a payment schedule if necessary, using this credit card authorization form.

I authorize Northwest Eye Clinic, Ltd., to keep my signature and credit card information on file and to charge my account for balances that remain unpaid when I call with verbal authorization to pay outstanding balance or make a payment specified in our agreement. I am authorizing the use of this card for only materials and services provided by Northwest Eye Clinic, Ltd.