Dr. Teresa D Hrach OD
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Millis, MA 02054
508-376-2539 fax: 774-849-3276

Patient Consent Form: The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health information (PMI) is protected for privacy. The rule was also created in order to provide standards for certain health care providers to obtain their patients' consent for uses and disclosures of PMI about the patient to carry out treatment, payment, or health care options. As my patient I want you to know that I respect the privacy of your PMI and will do everything I can to secure and protect that privacy. When it is appropriate and necessary, I provide the minimum necessary information to only those I feel are in need of your PMI.

You also have my support to full access of your medical records. I may have indirect treatment relationships with you and other health care workers and may have to disclose PMI for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of you PMI, but this must be in writing. Under this law, I have the right to refuse all or part of you PMI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please let me know. You have a right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Payment Agreement: I understand and agree that payment is due at the time services are rendered and that health, vision and accident insurance policies are an arrangement between an insurance carrier and me. I understand that this office will prepare and or file any necessary forms to assist me in making collection from my insurance company and that all services rendered to me are charged directly to me and that I am ultimately personally responsible for payment, regardless of insurance. Thus, persons are responsible for payment of all deductibles, co-pays, coinsurance and patient balances under their insurance plan. By signing below, person's receiving care from Dr. Teresa Hrach, agree to promptly and directly pay deductibles, co-pays, and co-insurances, as well as any unpaid balances not covered by the insurance policy/policies for services rendered to them and/or dependent family members. The office will bill insurances once established that the carrier will cover respective services. Persons agree to notify this office immediately with any changes in insurance, address or phone number. Co-pay is due at time of visit.

Treatment Rendered Without Proper Insurance Referrals/Authorization: Persons with insurance plans that require referrals and/or authorization for the medical practice of Dr. Teresa D Hrach, OD, are required to make payment for any/all services rendered in which a referral or authorization has not been secured as required. In addition, persons are for payment for services rendered if treatment is denied by their health insurance carrier.

The above policies will remain in effect for the remainder of this patient/doctor relationship until canceled in writing by the person responsible for payment.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED AS OUTLINED ABOVE.

____________________________________ ________________
Print Date

____________________________________ ________________
Sign Minor Name