

# LEE BOTTEM, DO, PLC

OCULOPLASTIC AND ORBITAL SURGERY

## Lee Bottem DO PLC Privacy and Billing Procedures Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Lee Bottem, DO PLC in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Lee Bottem, DO PLC.

### Acknowledge of Receipt of Notice of Privacy Practices Authorization of Release Information to Family/Friends or Others

I have received a copy of Lee Bottem, DO PLC Notice of Privacy Practices. I authorize Lee Bottem, DO PLC to release any information regarding my treatment; including test results, letters, pharmacy requests/refills and medical records, to the following individuals/entities. (Lee Bottem DO PLC may not release information or records to the names individuals/entities unless you identify them here):

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Lee Bottem DO PLC will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including test results, letters, pharmacy requests/refills and medical records. I will ensure this information is up to date at every visit.

### Authorization to use/release medical photos

\_\_\_\_\_ (Initial) I authorize for Lee Bottem, DO PLC to release my medical photos to my referring and primary care physicians for regarding my treatment.

\_\_\_\_\_ (Initial) I authorize for Lee Bottem, DO PLC to use my photographs, without compensation, for promotional purposes.

\_\_\_\_\_ (Initial) I further agree to hold Lee Bottem, DO PLC free and harmless from all claims arising from the use of said photographs used within the scope described above.

### Authorization to Treat and Bill

I consent to be treated by Lee Bottem, DO PLC. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize Lee Bottem, DO PLC to bill my medical insurance for the care I receive today and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Lee Bottem, DO PLC for all services performed and bill by Lee Bottem, DO PLC. I understand that I am responsible for all charges for the treatment I receive by Lee Bottem, DO PLC. I understand that Lee Bottem, DO PLC may utilize the Prescription Monitoring Program Service at no additional charge to me.

As a courtesy, Lee Bottem, DO PLC will bill my medical insurance. If I do not provide complete and accurate insurance information to Lee Bottem, DO PLC, I understand Lee Bottem, DO PLC may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Lee Bottem, DO PLC bill, I may owe Lee Bottem, DO PLC payment for services not covered by my insurance and I agree to pay these promptly to Lee Bottem, DO PLC.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Lee Bottem, DO PLC may choose not to bill insurance and my decline credit/debit and checks as a form of payment. I understand that if I fail to pay Lee Bottem, DO PLC for services provided to me, the balance owed may be sent to collections and I may incur collections fees of up to 25% in addition to the amount owed for services and/or treatment rendered. I understand that I may contact Lee Bottem, DO PLC to work out payment arrangements that may prevent this additional cost.

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

Name of Patient Representative\*: \_\_\_\_\_ Relationship to Patient\* \_\_\_\_\_

\*(Required if the patient is a minor or if the patient is unable to sign this form.)