# HIPAA Policies & Payment Policies

Acceptance of Blink Vision by Veatch HIPPA Policies and Payment Policies.

I authorize Blink Vision to use and disclose protected health information about me or my dependents to carry out treatment, payment and health care operations as defined by Blink Vision full notice of Privacy Practices (NPP). The NPP describes such uses and disclosures more completely. The full NPP was made available to me to review prior to signing this consent. I certify that the given information is correct to the best of my knowledge. I authorize Blink Vision to release any personal health information including diagnosis and records of any treatment or examination render to me or my dependents to third party payers. I authorize and request my insurance company to pay directly to Blink Vision.

I understand that my vision or medical insurance may pay less than the actual bill for services and I might be responsible for payment of additional or non-covered procedures for myself and my dependents. In the event my insurance company refuses payment, for any reason, I agree that I am responsible for my account balance.

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

____________________________________________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

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Representative Relationship to Patient

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BLINK VISION BY VEATCH