Daniel L. Cunningham O.D.
5550 Wares Ferry Road
Montgomery, Alabama 36117
(334-271-3937)

PATIENT AUTHORIZATION AND RELEASE OF INFORMATION

In order to help our patients we have arranged participation agreements with many major insurance carriers. For those companies which cooperate we can handle insurance claims directly through our office. For any others we will be glad to assist patients in filling out their insurance companies forms so that they may be reimbursed as quickly as possible.

Please read this agreement and sign below.

1. I authorize my insurance companies to make payments directly to Dr. Cunningham.

2. I understand that I am responsible for paying any deductible amounts, co-payments or other charges not covered by my insurance. If any costs are incurred in collecting over-due payments from me I will pay those costs also.

EXPLANATION OF PRIVACY PRACTICES

Our Commitment to Maintaining Confidentiality

Berry Optical/Daniel L. Cunningham, O.D. has always been committed to maintaining the confidentiality and privacy of your health information. Beginning in 2003, however we are now required to institute certain processes to protect your health information. These mandates are the result of the Privacy Rule of the Health Information Portability and Accountability Act of 1996 (HIPPA), which the federal government finalized in 2001 to help protect your private health information.

Privacy Notice

One such mandate is the distribution of the Notice of Privacy Practices you received or viewed today, which describes the ways that Berry Optical/Daniel L. Cunningham, O.D. can use and disclose your protected health information (which includes everything from your name to your diagnosis) to treat you, receive payment for treatment and for healthcare operations. Above and beyond the situations listed on the privacy notice, we will not use or disclose your information without your written authorization.

Acknowledgment of Receipt

I acknowledge that I received or viewed a copy of Berry Optical/Daniel L. Cunningham, O.D. Notice of Privacy Practices.

Patient name________________________________

Signature___________________________________ Date _______________________

To be completed by [Health Care Provider]:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):
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Signature of Representative _______________________________ Date__________________

We apologize for any inconvenience. Thank you for your patience as we comply with new regulations. They have been put in place to protect the most personal of all information- your health records.