



HIPAA FORM

TallmanEye.com (978) 688-6182

ACKNOWLEDGEMENT OF YOUR HIPAA RIGHTS

Tallman Eye reserves the right to modify the privacy practices outline in the available brochure.

I hereby acknowledge that the Tallman Eye Associates notice of privacy practices, pertaining to my HIPAA rights, has been made available to me on their website www.tallmaneye.com, or I may request to have a copy printed for me.

Financial Policy

Tallman Eye Associates verifies your insurance benefits. It is our policy to collect copays and ensure your account is current prior to your appointment. Upon check-out, we also collect your payment for the portion of today's charges which will not be reimbursed by your insurance. We reserve the right to reschedule your appointment if you are not prepared to make your payment.

Assignment of Benefits and Release of Information

I hereby authorize my insurance company to make payment directly to Tallman Eye Associates P.C. of medical benefits otherwise payable to me for treatment services rendered. I authorize Tallman Eye Associates P.C. to release all necessary information to secure the payment of benefits. I understand if my claim is denied for lack of coverage or referral requirement, I will be responsible for full payment.

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow your doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Name (please print): _____ Date of Birth: _____

Signature: _____

Haverhill

62 Brown Street
Suite 205
Haverhill, MA 01830
Fax (978) 521-6269

Lawrence

360 Merrimack Street
Entrance I, Suite 125, 1st Floor
Lawrence, MA 01843
Fax (978) 685-0055

Nashua

505 West Hollis Street
Suite 109
Nashua, NH 03060
Fax (603) 882-3020

Newburyport

21 Highland Ave.
Suite 1
Newburyport, MA 01830
Fax (978) 792-5788

North Andover

451 Andover Street
N. Andover, MA 01845
Fax (978) 655-8545

Salem, NH

29 Stiles Road, First Floor
Salem, NH 03079
Fax (603) 898-8568

Cataract and Laser Center

349 N. Main Street #6
Andover, MA 01810
Phone: (978) 475-0959