HIPAA PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that information regarding my office visit or purchase of prescription glasses will not be released to anyone without written approval below. The only exception to this is other doctor offices that have sent a release form with my signature. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature____Date_____________________

Print Name____

Information may be released to:____

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Insurance

I certify that I, or my dependant(s), have insurance coverage with the attached named insurance company (ies). The doctor and/or associates accept assignment from your insurance company directly, regarding all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature to all insurance submissions. The doctor may use health care information and may disclose such information to the named insurance company (ies) and their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or in one year from the date signed below.

Signature____Date_____________________

No Insurance

I certify that I do not have insurance coverage or am choosing not to use the coverage I have. I forgo the use of medical insurance benefits if there is a medical eye exam. I understand that I am financially responsible for all charges for services rendered. This consent will end when my current treatment plan is completed or in one year from the date signed below.

Signature____Date____________________

( ) No Change ( ) Changes Noted Below____

Signature Date

( ) No Change ( ) Changes Noted Below____

Signature Date

( ) No Change ( ) Changes Noted Below____

Signature Date

( ) No Change ( ) Changes Noted Below____

Signature Date