HIPPA: ACKNOWLEDGMENT AT RECEIPT OF PRIVACY NOTICE

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy and/or read a copy of the Notice of Privacy Practices for review and to keep for my records on the date identifies below.

I understand that the office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the office to perform its administrative duties, provide me with eye care services and products, process my vision/medical benefit claims and communicate with me regarding vision/medical claims and communicate with me regarding vision/medical care services provided by the office (for example, mailings of exam reminders or information for services/products provided by the office).

I can be assured that this office does not sell my personal health information of any kind to a third party for such party's own use. I authorize the office to submit my vision/medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision/medical services/products that I have received from the office.

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Patient Signature or Patient's Legal Representatitive *Date*

INSURANCE SIGNATURE ON FILE:

I certify the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to the doctor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as an agent, as above. I understand I am responsible for the balance of fees not paid by my insurance.

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Lifetime Patient Signature *Date*

REFRATION POLICY:

During your visit, a refraction may be preformed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases the sole reason for the appointment. The Centers for Medicare and some insurance companies consider a refraction to be a NON-COVERED service.

Please be aware it is the responsibility of the patient to pay for the refraction unless otherwise stipulated by your insurance carrier. Our office currently charges $55.00 for this procedure, but provides a prompt pay price of $25.00 to the patient when paid at the time of service. The refraction fee is in addition to the eye exam and is in addition to the patient's co-pay.

I have read the above information and understand I may be charged a prompt pay price of $25.00 for refraction at the time of service unless otherwise stipulated by my insurance company.

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Patient or Guardian's Signature *Date*

- **OFFICE USE ONLY** -

REFUSAL OF ACKNOWLEDGEMENT

For office use only: This section is to be completed by the office only if unable to obtain the patient's legal representatives written acknowledgement of receipt of the Notice of Privacy Practices for the following reasons:

________ (Please initial here) Patient or Patient's legal representative refused to sign.

________ (Please initial here) Other: (Please specify, e.g., emergency care)

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Provider / Associate Name (Print) *Provider / Associate Signature* *Date*