ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that The Eye Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING:

☐ I have read or had explained to me The Eye Clinic's Notice of Privacy Practice and agree to continue my care with The Eye Clinic under said terms.

OR

☐ I was given to opportunity to read The Eye Clinic's Notice of Privacy Practices and declined but wish to continue my care with The Eye Clinic under the terms of The Eye Clinic's privacy policies.

OR

☐ I have read or had explained to me The Eye Clinic's Notice of Privacy Practice and do not wish to continue my care with The Eye Clinic under said terms.

OR

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

I HAVE READ, I FULLY UNDERSTAND, AND I AM VOLUNTARILY SIGNING THIS FORM.

_____ _____

Patient, Representative, Guardian Date

_____

Relationship to Patient

Over Please

AUTHORIZATION TO COMMUNICATE W/ FAMILY OR OTHER PARTIES

If you wish that any information be discussed with someone OTHER than yourself, you must list their names below. Without this release The Eye Clinic cannot and will not discuss any information with anyone but YOU.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Information allowed to be discussed:
Medical: [] All [] Other (If you mark Other,
Billing: [] All [] Other please see front
Appointments: [] All [] Other desk staff)

The purpose of this authorization is:

[] At the request of the patient / patient's representative [] Other (state reason)

This authorization is valid for _____ days / months / years. If no date is provided, this authorization is valid for one year.
You have the right to revoke or change this authorization at any time; such change will only apply to information not already released. Should you wish to revoke or change this authorization, you must submit in writing to The Eye Clinic. You understand that you do not have to sign this form in order to receive treatment from The Eye Clinic.

_____ _____
(Patient or Patient's Representative Signature) (Today's Date)

Representative's relation to patient: _____

REFRACTION and NON-COVERED SERVICES

Medicare and some Commercial/PPO insurances do not consider a routine eye exam or refraction to determine changes in your glasses prescription to be medically necessary and do not cover these services. Refraction is necessary to prescribe glasses and contacts, but also assist in determining and assessing the ocular health of the eye or need for surgical procedures. **You are expected to pay for these services as well as any balance due because of applicable deductibles, co-insurances, co-pays, other non-covered services, authorization not obtained prior to visit, doctor not on insurance plan, or incorrect insurance information. I have read the above statement and understand refraction is a non-covered service. The co-pay is separate from and not included in the refraction fee or contact lens fitting fee.**

PATIENT'S SIGNATURE OR GUARDIAN _____
Date