Mallinger
FAMILY
EYE CARE

SIGNATURE ON FILE

Patient Name:_____

Patient Address:_____

Patient Primary Phone Number:_____

NAME OF INSURED (if other than the patient):_____

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny part or all of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of the office visit.

I hereby authorize payment directly to Dr. Mallinger for all services rendered to me by Dr. Mallinger or any of her authorized associates.

I authorize the release of all medical information to the insured's health insurance carrier that is acquired in the course of my examination or treatment or which may have a bearing on the benefits payable under this or any other plan that provides benefits or services. I authorize Dr. Mallinger or any of her associates to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "SIGNATURE ON FILE" form to be used in place of the original and that this copy may be used on all my insurance submissions.

_____ _____

INSURED OR AUTHORIZED PERSON'S SIGNATURE **DATE**

Acknowledgement of Receipt of Notice of Privacy Practices

Signing this document signifies that you understand our Privacy Policies and that a copy in our office is available for your review.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** describes these uses and disclosures in detail. I acknowledge that I have read and understand the ***Notice of Privacy Practices*** at Mallinger Family Eye Care.

_____ _____

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE OF PATIENT **DATE**

If signing as a parent, guardian or personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

RELATIONSHIP TO PATIENT **PRINT NAME AND SOURCE OF AUTHORITY TO SIGN FORM**