ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices outlining my rights regarding my health information and detailing how my health information may be used and disclosed as permitted under federal and state law.

By law, without your authorization, The Vision Center cannot communicate with:

- Your spouse
- Your adult children or caregivers
- Your parents (if age 18 or older)
- Your other healthcare physicians

Indicate below the names of the people who we may communicate with regarding your appointment, medical/vision or account information:

☐ Spouse: _____

☐ Adult Children: _____

☐ Parents/Caregivers: _____

☐ Health Care Physicians: _____

☐ Other: _____

Patient or Guardian signature: _____ Date:_____

Relationship (if not signed by patient): _____

Internal Use Only

If patient / patient's representative refused to sign acknowledgement, please document the date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

THE VISION CENTER

Name: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____

Daytime Phone:_____

Email:_____

Preferred Contact Method: ☐ Cell Phone ☐ Email ☐ Text ☐ Other (please explain) _____

Date of Birth:_____

Gender: _____

Patient Social Security Number: _____

Occupation, Employer:_____

Marital Status: _____

Language, Race, Ethnicity: _____

Name of person responsible for account: _____

This section only applies if we are filing insurance for you:

Vision Insurance: _____Member ID: _____

Primary member name, if not self:_____

Primary member social security number: _____

Primary member date of birth: _____

Medical Insurance: _____

Member ID: _____ Group Number:_____

Primary member name, if not self:_____

Primary member social security number: _____

Primary member date of birth: _____

Secondary Vision/Medical Insurance: _____

Member ID: _____ Group Number:_____

Primary member name, if not self:_____

Primary member social security number: _____

Primary member date of birth:_____

Patient or Guardian signature: _____ Date:_____

Relationship (if not signed by patient): _____

THE VISION CENTER

Patient Financial Responsibility

We are committed to providing you with the best possible vision care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express.

2. Our office participates with a variety of insurance plans. It is your responsibility to:

- Bring your current insurance card to every visit
- Be prepared to pay your co-payment and/or co-insurance at each visit.
  - Payment can be made by cash, check, Visa, Mastercard, Discover, or American Express
- For care not covered, deemed medically unnecessary or cosmetic by your insurance company, payment in full is due at the time of the visit.

3. If the total patient balance due cannot be paid in full, arrangements must be made prior to service being rendered.

4. **Referrals**: It is your responsibility to bring any required referrals for treatment to, or prior to your visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered.

5. If the patient is a minor (17 years or younger), a parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card.

6. If you have any questions about your insurance, we are happy to help. Specific coverage issues, however, should be directed to your insurance company's member services department.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be asked prior to services provided.

Patient or Guardian signature: _____ Date:_____

Relationship (if not signed by patient): _____