ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices adhered to by Vaught Eye Associates detailing how my health information may be used and disclosed as permitted under federal law, and outlining my rights regarding health information. By signing below I acknowledged and I was given/offered a copy of the Notice of Privacy Practices and consider myself informed.

Signed_____ Date_____

Relationship to patient if other than self _____

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? **IF YES**, WHOM?

Name(s):_____

_____

May we discuss via phone? YES or NO May we leave a message? YES or NO
May we fax the information? YES or NO **if YES**, List phone/Fax numbers: _____

Internal Use only:
If patient/parent's representative refuses to sign acknowledgement, please document date and time notice was presented to the patient and sign below.

Presented on (date & time)_____ By (name & title)_____

RELEASE OF INFORMATION AND SIGNED CONSENT

INSURANCE LIABILITY AND FINANCIAL RESPONSIBILITY

As part of our effort to provide outstanding services we will make every attempt to file your medical claim. Please note you are ultimately responsible for fees associated with your care. The payment of Copays, Coinsurance, Deductibles and all non-covered items or services if not otherwise insured are expected at the time of service. YOU MAY BE BILLED FOR SERVICES RENDERED IF IT IS DETERMINED BY YOUR INSURANCE COMPANY THAT YOU ARE FINANCIALLY RESPONSIBLE.

Occasionally, your insurance company, this office or a covered entity designated by healthcare law may review your claims or record and determine at a later date that you were financially responsible for past date of service.

Your signature below also acknowledges that in filing any claim on your behalf, your records may be requested by your insurance company in aid or payment. You understand that your records contain Protected Health Information and may contain information from referring providers, HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, and sexually transmitted diseases, as well as additional medical, mental, and physical ailments.

WE CANNOT FILE YOUR CLAIM TODAY WITHOUT YOUR CONSENT

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND PERMISSION TO FILE MEDICAL AND/OR VISION CLAIMS

Signed_____ Date_____