Privacy Practices Acknowledgement

Printed Patient Name: ____________________________________ Patient Birth Date:_______________

We at Lawrence Family Vision Clinic are required by law to maintain your privacy and provide you with our privacy practices. If you would like a copy of the privacy notice or have questions, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_______________________________________ ____________________
Signature of patient or patient's representative/parent Date

____ ______________________
Printed name of patient or patient's representative/parent Relationship to patient

Please list any persons we may share your medical information with:

Name:_____________________ Relationship____________________
Name:_____________________ Relationship____________________
Name:_____________________ Relationship____________________
Name:_____________________ Relationship____________________
Name:_____________________ Relationship____________________

Billing agreement

Payment including but not limited to co-pays and deductibles are due in full at time of service. Return checks are subject to a $30 return check fee and will be taken out of your bank account until paid in full. Your first statement is at no charge. After the first statement, we assess a $5 statement fee. If no payments are made on your account balance for 90 days, a $50 collection fee will be assessed and turned over for collection. Accounts turned over will be responsible for collection costs, including but not limited to collection fees, court costs, and attorney fees.

Signature____Date____________________

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. It is your responsibility to know your benefits including if we are in network with your plan, your eligibility, and what vision coverage you have.

Insurance(s) to file ____

I hereby authorize payment of my medical and surgical insurance benefits to Lawrence Family Vision Clinic. I authorize Lawrence Family Vision Clinic to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. I also understand that if I do not provide a copy of my insurance card and driver's license, Lawrence Family Vision Clinic may not be able to submit my insurance for me.

Signature_______________________________________Date_____________________

Checked in by: _____________________________________ (staff)