FAMILY visionclinic
& Dry Eye Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Family Vision Clinic Privacy Officer.

Our Notices of Privacy Practices located in the clinic reception area describe in more detail how your health information may be used and disclosed, and how you can access your information. I acknowledge the brochure has been made available and is readily accessible.

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Family Vision Clinic all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I authorize the use of my signature on all insurance submissions.

Family Vision Clinic may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed, or one year from the date signed below.

_____ _____

PRINTED NAME of Patient/Parent/Guardian/Personal Representative Date

_____ _____

SIGNATURE of Patient/Parent/Guardian/Personal Representative **RELATIONSHIP to** Patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

❑ I give consent to Family Vision Clinic to disclose information regarding financial and/or insurance concerns.

❑ I give consent to Family Vision Clinic to share care and/or treatment plans.

Family Vision Clinic has my consent to share the above initialed information with the following persons ending one year from signature date:

_____ _____

PRINTED NAME of AUTHORIZED CONTACT: First & Last Name **RELATIONSHIP to** Patient

_____ _____

SIGNATURE of Patient/Parent/Guardian/Personal Representative **CONTACT INFORMATION**

Last Revised: 04-27-2015