Acknowledgment of Notice of Privacy Practices

The law requires that AccuVision EyeCare and Foresight Optometry make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- □ I have read or had explained to me Foresight's Notice of Privacy Practice and agree to continue my care with Foresight under said terms.
- □ I was given to opportunity to read Foresight's Notice of Privacy Practices and declined but wish to continue my care with Foresight under the terms of Foresight's privacy policies.
- □ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Sign Name *(Patient, Parent/Guardian if patient is a minor)* Date

_____ _____

Print Name Relationship

Authorization and Assignment of Benefits

By signing this form below, I authorize the release of any medical information necessary to process insurance claims and request payment of medical benefits to be made directly to AccuVision EyeCare or Foresight Optometry, unless payment is made in full at time of service. I understand that it may be necessary for me to bill my own insurance company directly.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under your benefit plan or we were not made aware of your coverage at the time of services. (Some non-contracted insurance companies have disclaimers stating that they will not guarantee coverage as quoted over the phone at the time of our coverage inquiry).
3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracted provider.
5. All charges are due & payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above-stated office policies. I agree to comply with these policies. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Sign Name *(Patient, Parent/Guardian if patient is a minor)* Date

_____ _____

Print Name Relationship