



PRIMARY EYE CARE

DR. JOE C KEA

Acknowledge of Notice of Privacy Practices

**By my signature below, I acknowledge that I have been offered a copy of
Primary Eye Care's Notice of Privacy Practices:**

Patient Name: _____ Patient date of Birth: _____

Name of Primary Care Physician: _____ Dr. Location: _____

Family Dr. Phone #: _____

Any physician, staff, employee or representative of Primary Eye Care has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____ Name	_____ Relationship	_____ Phone Number (s)
_____ Name	_____ Relationship	_____ Phone Number (s)
_____ Name	_____ Relationship	_____ Phone Number (s)

_____ I choose **not** to use insurance benefits and pay out of pocket. I instruct Primary Eye Care not to share information about my treatment with my health plan.

I understand that authorizing the release of my information to the above individual (s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to Primary Eye Care or complete a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

Patient or Guardian's Signature: _____ Date: _____



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SIGNATURE ON FILE

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Companies may have a fixed allowances or percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the deductible, co-insurance, or any other balance not paid by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for any balance your insurance does not cover.

FINANCIAL RESPONSIBILITY

By signing this statement you agree to be financially responsible for all charges.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

*** Please Update If Needed ***

Address: _____

City: _____ State: _____ Zip: _____