

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE - HIPAA

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the “Notice”) I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my record on the date identified below.

I understand that Swartz Creek Vision Center may use and disclose necessary personal health information (for example my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Swartz Creek Vision Center to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Swartz Creek Vision Center (for example mailings of exam reminders or information about services/ products provided by Swartz Creek Vision Center).

I can be assured that Swartz Creek Vision Center does not sell my personal health information of any kind to a third party for such party’s own use. I acknowledge and agree that Swartz Creek Vision Center may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products I have received.

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Patient Signature or Patient’s Legal Representative Date

AUTHORIZATION TO BILL INSURANCE

Swartz Creek Vision Center participates with many different insurance companies. For your convenience, we will complete insurance forms and bill your vision or medical insurance where applicable. Any copays or deductibles not met at the time your claim is processed or denial of a claim will be forwarded on to the patient or responsible party. Your signature below authorizes the release of medical information necessary to process the claim and will assign benefits to Swartz Creek Vision Center.

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Patient Signature or Patient’s Legal Representative Date