

## Patient Authorizations of Release

**Patient's Printed Name:** \_\_\_\_\_

I hereby authorize my doctor to release to my insurance carriers any medical or other information needed for all services I receive. I request all insurance payments be made directly to my doctor. I understand that if my insurance company does not pay within 45 days or decides that a service is "non-covered" that a bill will be sent directly to me. I further understand that I am responsible for any deductible, coinsurance, co pays and refraction fees at the time of service.

I also understand that, if at any time, I change my insurance coverage to a managed care plan or change my primary care physician, I am responsible for notifying your office of such changes. If I fail to notify the office or fail to obtain a valid referral prior to my visit, and decide to be seen by 1<sup>st</sup> Eye Care, I understand that my services may not be covered by my insurance company and I will be responsible for all charges incurred.

**X** \_\_\_\_\_  
**Signature of patient or personal representative**

\_\_\_\_\_  
Date

### Acknowledgement of Notice of Privacy Practices – HIPAA

I understand that as part of the provision of healthcare services, 1<sup>st</sup> Eye Care creates and maintains health records and other information describing, among other things, my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment.

I have read, had explained to me, or was given the opportunity to read 1<sup>st</sup> Eye Care's Notice of Privacy Practices. This explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**X** \_\_\_\_\_  
**Signature of patient or personal representative**

\_\_\_\_\_  
Date

Please list the names of the persons with whom you authorize 1<sup>st</sup> Eye Care to communicate regarding your medical care and insurance/financial records. If no names are listed, 1<sup>st</sup> Eye Care is not authorized to release any information of any kind to family or friends on your behalf.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship