Consent To Bill Insurance and Receipt of Privacy Policy

Name of Patient:_____ Date of Birth:_____

I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill. Payment in full is due at time of service unless other arrangements have been made.

Note: Bring your vision and medical insurance cards to your appointment. *If no insurance card is available*, please supply the name of the insurance company and ID number in the space below.

Ins. Company:_____ ID#_____

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Consent to Bill Insurance, Authorization, and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and records of any treatment or examinations rendered to me or my child to: _____.

X_____ _____

Signature of patient (or parent, if minor) Date

HIPPA Privacy Policy Acknowledgement:

I have received or was offered and declined a notice of privacy practices.

X_____ _____

Signature of patient (or parent, if minor) Date