HIPAA PRIVACY Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices; I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that O'Rourke Vision Care 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 O'Rourke Vision Care 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 O'Rourke Vision Care (for example, mailings of exam reminders or information about services / products provided by the Location).

I can be assured that O'Rourke Vision Care does not sell my personal health information of any kind to a third party for such party's own use. I authorize O'Rourke Vision Care to submit my vision/medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the services and products that I have received from O'Rourke Vision Care.

TODAY'S DATE: ______________________ DATE OF BIRTH ______________________ PHONE # ____________________________________

PATIENT: **FIRST** NAME: (PRINT) __________________________ Middle Initial _______ **Last** Name ___________________________________

Patient Address _______________________________________ City _______________________________ State ________ Zip ____________

X Patient Signature or Patient's Legal Representative ____

May we Release Information?

I authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be released to any of the following, spouse, children, other; or check box for information to **NOT** be released.

Spouse: ____________________________________

Child(ren): __________________________________

Other: _____________________________________

☐ Information is not to be released to anyone

May we leave Messages?

If unable to reach me: (CHECK ONE)

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

Also sign below

Note: **Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. I understand there is a $25 cancellation fee if I do not provide 24hrs notice.**

X Patient Signature or Patient's Legal Representative: ____ Date: __________________

Witness: ____ **Date:** __________________