

Patient Name _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I was offered and declined or received a copy of the Notice of Privacy Practices for this office.

X _____
Signature

Date

Printed Name

Initial one of the options below:

_____ I understand the risks and agree to allow communication of health information between myself and Nobbe Eye Care Center through standard email communications (i.e. requests for prescriptions)

_____ I decline to allow communication of health information between myself and Nobbe Eye Care Center through standard email communications (i.e. requests for prescriptions)

X _____
Signature

Date

E-mail

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Nobbe Eye Care Center.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Collection Policy

I understand that I am responsible for charges not paid by the insurance plan (if insurance is applicable). I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 30%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and take reasonable steps to verify my credit or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance permission to contact me regarding this transaction or any future transaction at any of the telephone numbers of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message.

X _____
Signature

Date

Printed Name

Relationship to Patient _____



NOBBE EYE CARE
a division of ORTHOCARE EYECARE