NAME: _____

THIS NOTICE APPLIES TO THE FOLLOWING FAMILY MEMBERS:

_____

PRIVACY POLICY

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Optix Eyewear/Dr Robert Collins.

_____ _____

Date **Signature**

FINANCIAL DISCLAIMERS

_____ **Eligibility for medical insurance and/or routine vision benefits**

(Initials) We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only and is not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility.

Liability

I understand that account balances and co-payments are due at the time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Optix Eyewear/Dr. Collins. I also authorize Optix Eyewear/Dr. Collins to release any information required for payment to be made. ***If my plan carrier does not pay, or only partially pays, I understand I am responsible for payment in full or the remaining balance.*** My signature below verifies that I understand this agreement and the above financial disclaimers.

_____ _____

Date **Signature of Patient (if over 18) or Parent of Patient**