Patient Name _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

Initial below:

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

Initial one of the options below:

_____I understand the risks and agree to allow communication *of health information* between myself and Chittick Eye Care through standard email communications (i.e. requests for prescriptions).

_____I decline to allow communication of health information between myself and Chittick Eye Care 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 Chittick Eye Care.

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

_____ Relationship to Patient_____
Printed Name

(OVER)

Acknowledgment of Availability of Contact Lens Prescription

I understand that upon the finalization of contact lens fitting services a copy of my prescription will be available through the patient portal. Please visit www.chittickeyecare.com to login.

_____	_____
Date	Signature

CHITTICK
EYE CARE