ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) & understood the notice.

_____

Patient Name (Print)

_____

Parent/Authorized Representative/ (if applicable)

Authorization for Release of Information

I hereby authorize Aldridge Eye Institution to disclose my individual medical information to the person listed below. I understand that this authorization is voluntary and will not expire, however it may be revoked at any time by notifying Aldridge Eye Institute in writing.

Person(s) allowed to receive my medical information Relationship to patient

_____

_____

NONCOVERED SERVICE: Items that are considered not medically necessary and/or non-reimbursable services by your insurance company, i.e.. a refraction (the portion of the exam that measures your best possible corrected vision for your eyeglasses prescription, if applicable). While this information is important in the diagnosis of your refractive state, it is not a medical necessity. Medicare and most other insurance carriers do not cover this service. You are responsible for this charge to be collected at the time of service. The remainder of your visit will be billed to your insurance carrier, when applicable. However, if you are covered by North Carolina Services for the Blind, North Carolina Healthchoice, or any other routine vision policy, they will cover this expense.

I hereby acknowledge the above and agree to make payment for all non-covered services.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PRESENT PROOF OF ANY VISION CARE INSURANCE AT THE TIME OF MY VISIT. FURTHERMORE, I UNDERSTAND AND AGREE TO THE FACT THAT ONCE MY SERVICE HAS BEEN COMPLETED, ALDRIDGE EYE INSTITUTE, O.D., P.A. CANNOT FILE OR ACCEPT ANY INSURANCE WHICH WAS NOT PRESENTED PRIOR TO SERVICE.

Signature_____Date_____