ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____

The undersigned acknowledges receipt of copy of the currently effective Notice of Privacy Practices for Cincinnati Vision Group, LLC.

X_____ _____

Please **print** patient name Signature of Patient **(if 18 or older)**

X_____ _____

Legal Representative /Guardian Relationship of Legal Representative/Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents,grandparents, and any caretakers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

FINANCIAL AGREEMENT

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full financial responsibility for any charges incurred if:

*The services rendered or supplies used/purchased are not covered under my insurance plan;
* My insurance plan requires that I pay a deductible, co-payment, or co-insurance.
*The provider you are scheduled with is not in network with your insurance plan.
* There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
* My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

Payment to be made to Cincinnati Vision Group, LLC by my insurance carrier for services rendered or product received; may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party; to pay for my co-pay and other charges that are not covered by my insurance carrier or make financial arrangements if applicable. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.

I have read and understand the above information. My signature here indicates compliance with the above policies.

X_____ _____

Patient Signature(if 18 or older) **Patient** Date of Birth

For patients under 18 below:

_____ _____

Printed name of Responsible party **Responsible Party** Date of Birth

X_____ _____

Signature of Responsible party **Date**