EyeStyles, llc

We welcome you to our practice and ask that you kindly complete all information on this sheet.

Acknowledgement of Receipt of this Notice:

This Practice is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for EyeStyles.

_____

Print name

_____ _____/_____/_____

Signature of patient or authorized representative Date

Medical Insurance and Accounting Policies:

As part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1) The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.

2) When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, copays, deductibles, lapses, ineligibility or termination of coverages. Unpaid balances are the sole responsibility of the patient.

3) To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.

4) I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.

5) I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

6) I am aware that any balance left on my account is my sole responsibility. If after multiple attempts to collect payment the balance remains unpaid, EyeStyles reserves the right to send the balance to collections.

_____ _____/_____/_____

Signature of patient or authorized representative Date