STATEMENT OF RESPONSIBILITY
I authorize the release of my medical records from Hawks Prairie Vision Clinic in order to process any claims. I hereby authorize my insurance benefits to be paid directly to Hawks Prairie Vision Clinic for services rendered. I understand that as the patient (or the patient's parent/guardian) I am responsible for any unpaid balance on this account. I also understand that if any charges are not covered by insurance, workers' compensation or other third-party payers, I am responsible for full payment.

INSURANCE INFORMATION
If the chief complaint or reason for the visit(s) is due to a medical situation such as dry eyes, diabetes, floaters, cataracts, burning or itching of the eyes, infection, eye pain, or any other medically related condition(s), the service(s) would be billed towards **MEDICAL** insurance, NOT vision insurance. If the doctor suspects or is managing disease, he/she may order additional tests, including digital photography, that would also be billed to **MEDICAL** insurance. Vision insurance does not cover these services
Depending on your policy, visits may be subject to a deductible, copay, and/or co-insurance. This is an agreement made between patient and insurance. Hawks Prairie Vision Clinic does not set these terms. It is ultimately the patient's responsibility to understand their coverage.

Signature **Date**

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT
Hawks Prairie Vision Clinic keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

AUTHORIZION FOR RELEASE OF HEALTH INFORMATION
For release of protected health information to a third party not involved with the payment, treatment or health care operations of the patient.
I authorize Hawks Prairie Vision Clinic to release my personal Health Information to the following individual(s) or facility:

Name **Relationship**

Name **Relationship**

By signing below, I acknowledge that I have received the Notice of Privacy Practices.

Patient (or legal guardian) Signature **Date**

Printed name if signed on behalf of the patient **Relationship**