



A MEMBER OF *VISION SOURCE*[®]

Acknowledgement of Receipt of Privacy Practices (HIPAA)

In the course of providing you service, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat and obtain payment for our services, and to conduct health care operations involving this office. The Notice of Privacy Practices describes these uses and disclosures in detail.

Approved Contact Person(s)

The following individual(s) are approved contacts, and The Office may answer all questions and requests for information related to the privacy of your health information as well as dispense goods to.

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Insurance Signature of File

I certify that the information given by me in applying for insurance and/or Medicare payments is true and correct. I authorize my doctor and this office to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Mitchell Reinhold, OD LLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I understand that if my insurance fails to make payment within 90 days for services rendered that I will be responsible.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices and consent to the language throughout this document. I also consent to allowing my signature to be kept on file for Insurance purposes as well as proof of ultimate financial responsibility in the event my insurance does not pay for services.

Date: _____ Print Patient's Name: _____

Patient/Parent/Guardian Signature _____