Acknowledgment of Notice of Privacy Practices

Lake Havasu Family Eyecare

2277 Swanson Ave Ste 100
Lake Havasu City, AZ 86403
928-855-5026

1990 McCulloch Blvd Ste 101
Lake Havasu City, AZ 86403
928-275-6339

Patient Name: _____

The law requires that Lake Havasu Family Eyecare make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

_____ I was given the opportunity to read, have read or had explained to me Lake Havasu Family Eyecare's Notice of Privacy Practice prior to any services offered.
_____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Lake Havasu Family Eyecare to release my personal health information to the following individuals:

_____ _____

_____ _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

_____ I authorize the release of medical information to my vision plan
_____ I do not authorize the release of medical information to my vision plan

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Lake Havasu Family Eyecare all insurance benefits (including Medicare and government benefits), otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the release of my health care information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
I acknowledge that I am financially responsible for my account and/or dependents accounts. I agree to keep my account in good standing and pay all balances due. Should it become necessary, I agree that LHFE can send my bad debts to a collection agency and I am responsible for any fees assessed by that agency.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____
Representative Signature Relationship to Patient