Wadsworth Eye Clinic, Inc.

Acknowledgment of Receipt of Notice of Privacy Practices

Wadsworth Eye Clinic, Inc. respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

Please print your name and sign below indicating you have received our Notice of Privacy Practices. Guarantors are required to sign on behalf of minors.

Patient Name: ______________________________

Signature: ______________________________ Date: ______________

Please indicate below your preference about our use and disclosure of your health information. Wadsworth Eye Clinic, inc. will release health information to all guarantors of minors and primary care physicians.

□ I,_____________________________, authorize the person(s) listed below to discuss my care with or receive my health information provided by Wadsworth Eye Clinic, Inc.

Name	Relationship	Phone Number

□ I,_____________________________, do not authorize Wadsworth Eye Clinic, Inc. to disclose my health information to any other person except me as the patient.

Over →

Wadsworth Eye Clinic, Inc.

Signature on File • Assignment of Benefits • Financial Agreement

I hereby certify that the insurance information provided by me is correct and that Wadsworth Eye Clinic, Inc. will file my claim to the insurance company that I provide to the practice.

I request that payment of authorized insurance benefits be made on my behalf to Wadsworth Eye Clinic, Inc. for services provided. I understand that Wadsworth Eye Clinic, Inc. may release information necessary to process my claim.

I understand that I am financially responsible for services that are not covered by my insurance plan. I agree that in return for the services provided, I will pay my account at the time service is rendered or will make arrangements satisfactory to the practice. If my insurance company applies a co-payment or deductible to my visit(s), I agree to promptly pay them to Wadsworth Eye Clinic, Inc. ***However, I understand that I am primarily responsible for the full payment of my bill.***

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Patient Name (Please Print)

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Signature of Patient or Responsible Party Date