LONE STAR
Vision Group

Acknowledgment of Notice of Privacy Practices

The law requires that Lone Star Vision Group 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 Lone Star Vision Group'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

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide authorized individual with whom we may share your medical records.

Authorized Individual's Name: _____ Phone Number: _____

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 release of medical information to my vision plan

Statement of Financial Responsibility

I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year, per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out of pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and, if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

I have read and understand both the Acknowledgement of Notice of Privacy Practices & Statement of Financial Responsibility

Signature of Patient (or Parent/Guardian): _____ **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 and consent to such care.
Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

Representative Signature Relationship to Patient _____

Other individual(s) Authorized _____