

HIPAA Acknowledgement of Receipt

I acknowledge that I received a copy of Children's and Family Eyecare's Notice of Privacy Practices.

Signature: _____

Date: _____

Insurances accepted:

VSP * Blue Cross/Blue Shield * Eyemed

INSURANCE AUTHORIZATION

I request that payment for authorized Insurance benefits for any services furnished me, be made on my behalf to: Children's Eyecare, P.C.

I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X _____

Date _____

Please provide the following Member Insurance Information:

Member's Name: _____

Member's ID#: _____

Member's Date of Birth: _____

Relationship to Patient: _____

