Advanced Financial Responsibility Notice

There is a documented insurance Law that *REQUIRES* your signature as documentation that you understand the following policy:

Depending on one's eye condition, and/or, the need to rule out certain eye diseases, different ophthalmic procedures *may* be required in addition to your eye exam. The yearly eye exam is covered under most insurance benefits plans, however some procedures and medical devices, although necessary for the proper diagnosis and treatment of disease, may not be covered.

Once you sign this form, we will be glad to submit your claim on your behalf, to your insurance company for reimbursement.

You will be informed of any non-covered procedures however you will be responsible for payment at the time of service. This also applies to cash paying patients.

X_____

Signature

X_____

Print Name

Eagle Ranch

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7201 Boat Club Rd.
Ft. Worth, TX 76179

Ph. 817-750-2233
Fx. 817-750-2266

Member
American Optometric Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Contact Person:
Our contact person for all questions, requests or for further information related to the privacy of your health information is:

_____ _____
Name Address

Complaints:
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:
We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: _____ ____, 20___

NF 5/2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of _____ O.D., Notice of Privacy Practices.

Date _____ Patient name _____ Signature _____