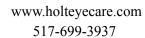
Privacy Policy and Confidential Communication Form

HIPAA (Privacy Policy) Acknowledgment

For the full acknowledgement click here:

I acknowledge to have received a copy of the HIPAA Privacy Policy of this office and have read, understood, and agreed to all the information.

Print (Patient/Responsi	ole Party):				_
Sign (Patient/Responsib	le Party):				_
Date:/					
I authorize the release of individuals (Please put 1				ne or in-person to the	he following
1. Name of person	•		Relationship):	
Primary contact	number:		_		
2. Name of person	·				
Relationship:		Primar	y contact numb	er:	
With the use of l		alth Records, th	0	-	•
RACE:					
American Indian	Black	Native Hawaiian	Asian	Caucasian	Other
ETHNICITY:					
Hispanic or Latino	Not His	Not Hispanic or Latino		No Answer	
PREFERRED LANGU	JAGE:				
American Sign Languag	e Arabic	English	French	German	Italian
Korean Polish	Spanish				
HEIGHT:fti	1	WEIGHT	:lb	S	





Electronic Communications & Billing

Spartan Eyecare

Holt Eye Care, PLLC utilizes a third-party electronic communication system. These communications will be used for scheduling, reminders, and also for collecting or sending pertinent clinical, insurance information, invoices, billing &/or collections information as is necessary to provide your treatment and/or to correspond. I understand that communications via the means as described above are not always secure. Although it is very unlikely, there is a possibility that information you or we send may be intercepted or it may also be read by other parties besides the person to whom it is addressed. Moreover, I understand that by federal law, Holt Eye Care, PLLC may not use/disclose my healthcare information without my authorization.

without my authorization.
Patient/Responsible Party Signature:
Date:/
Please provide a primary <u>email address</u> & <u>phone number</u> for any updates, newsletters, billing, and confidential communications.
E-mail:
Phone Number:
Please circle your <u>preferred</u> type of communication: Home Cell/Text Email
By signing, I acknowledge and understand:
Payment for all services and products is the responsibility of the patient. I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.
I understand there is a returned check fee applied to every returned check.
I authorize the release of medical information concerning my illness and treatment by Holt Eye Care, PLLC to my insurance company.
I also authorize the release of my personal medical information to any doctor whom I may be referred to.
A restocking fee may apply to any returned glasses and/or contacts due to the item(s) being a customized product
I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.
I authorize payment of my insurance benefits to Holt Eye Care, PLLC.
Patient/Responsible Party Signature:
Date:/
If you're new to Holt Eye Care, we would love to know how you heard about us! Word of Mouth Social Media Digital Advertising

Draper Eyewear

Other: