ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Medicaid/Medicare/Private Insurance authorization for assignment of benefits/information release:

I, the undersigned, authorize payment of medical/vision benefits to Fremont Vision Source for any services furnished to me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

HIPAA Acknowledgement:

I have read or had explained to me Fremont Vision Source's Notice of Privacy Practices and agree to continue my care with Fremont Vision Source under said terms.

Communication with Family and Friends:

I authorize Fremont Vision Source to disclose information about my medical/vision conditions and/or treatment to the following people:

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient