



Notice of Privacy Practices Acknowledgement

By signing this form, I acknowledge that I have received a copy of the **Notice of Privacy Practices**. I also acknowledge that I understand what is written (or that I have had the **Notice** translated as is practical), and that I have been given the chance to ask, and have answered, any questions about its contents.

Signature

Date

Printed Name

Name of Child or Dependent (if applicable)



Financial Responsibility

Exams for some minor eye conditions, routine eye exams and exams for glasses are frequently **not** covered by even the most comprehensive medical insurance. Unfortunately, this can result in a substantial out-of-pocket expense for you or your family. It is a goal of our practice to avoid any circumstance where you would unknowingly have out-of-pocket expenses. By signing below, you assume full responsibility for all allowable charges not covered by your medical insurance.

Please contact your insurance company in advance if you have any questions about what expense you may incur. If your insurance will not allow a visit to our office and you prefer not to pay out-of-pocket, we can refer you to several competent optometrists in the area.

Patient or Parent/Adult Guardian Signature

Date