Financial and HIPAA Privacy Practices Standards

Patient Name (print) **Date of Birth**

Email address

FINANCIAL POLICY

I understand and agree to this financial policy.

I have read the financial policy and agree that a photocopy shall be considered as effective and valid as the original. **REGARDLESS OF WHAT INSURANCE COVERAGE I HAVE, I AM ULTIMATELY RESPONSIBLE FOR THE TIMELY PAYMENT OF MY ACCOUNT.**

Patient / Parent Signature Date

HIPAA PRIVACY PRACTICES STANDARDS

I acknowledge I have been given an opportunity to read a copy of Premier Eye Care Notice of Privacy Practices.

Patient / Parent Signature Date

I give permission for :

Please Print Name

to have access to my medical records .

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ **Individual refuse to sign**

Other (Please specify) :

PEC Business Associate: ____________________________