Pearland Eye Care

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Pearland Eye Care Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

I acknowledge that I have been given the following options related to communicating with Pearland Eye Care, its

I agree to allow Pearland Eye Care doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Pearland Eye Care. I understand that clinical information will not be part of this message.

Please circle one of the following:

Yes, I agree **No, I do not agree**

I agree to allow Pearland Eye Care to send me marketing materials/ clinical information concerning services that may contain my name and that of Pearland Eye Care and/or an individual optometrist or ophthalmologist providing care at Pearland Eye Care.

Please circle one of the following:

Yes, I agree **No I do not agree**

Assignment & Release/Services & Materials Rendered: I hereby authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for non-covered services. I authorize the physician to release information required to process this claim. I also acknowledge that if I am not using insurance benefits, payment is expected in full at time of services and/or materials rendered.

Signature of responsible party: _____