ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Newton Family Eye Care, PC make every effort to inform you of your rights related to your personal health information. Newton Family Eye Care, P.C. give you the following options to receive our Notice of Privacy.

Please read the following carefully:

I was given the opportunity to read Newton Family Eye Care, PC's Notice of Privacy Practices and declined but wish to continue my care with Newton Family Eye Care, PC under terms of Newton Family Eye Care, PC's privacy policies.

I have read or had explained to me Newton Family Eye Care, PC's Notice of Privacy Practice and agree to continue my care with Newton Family Eye Care, PC under said terms.

The notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNERSTAND THIS FORM AND AGREE TO NEWTON FAMILY EYE CARE, P.C.'S PRIVACY POLICIES AND WOULD LIKE TO CONTINUE. IF, AFTER HAVING READ OR HAVING EXPLAINED NEWTON FAMILY EYE CARE, P.C.'S NOTICE OF PRIVACY PRACTICE, YOU DO NOT WISH TO CONTINUE YOUR CARE WITH NEWTON FAMILY EYE CARE P.C. UNDER SAID TERMS, DO NOT SIGN BELOW.

__________________________________ ____________________
Patient Date

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

__________________________________ ____________________
Representative Relationship

SIGNATURE ON FILE

I request that payment of authorized Medicare or other Medical insurance benefits be made either to me or on my behalf to Newton Family Eye Care, P.C. for serviced furnished to me by the provider. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services or other insurance carriers and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be valid as the original.

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Patient/Guardian Signature Date

If our office accepts assignments from your insurer, we will be billing your insurance company for fees for your office visits and/or materials. If you are denied benefits for any reason, you are responsible for any unpaid fees for these services or material

I understand that I am financially responsible for all charges iincurred which are not covered by insurance payment.

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Patient/Guardian Signature Date