Patient Name:____ Date:___________

Notice of Privacy Practices - Acknowledgment of Receipt

I acknowledge that I have been offered or have received a copy of Loman Eye Care's Notice of Privacy Practices.

X Signature:____ Date______________

Authorization To Release Information for Insurance Filing

I authorize the release of my information to my insurance carriers, including Medicare, for information required to file or resubmit my claim. I further authorize my insurance companies to pay Loman Eye Care directly on my behalf.

I further authorize all insurance companies including Medicare Supplement to provide any information to Loman Eye Care that is required to resubmit any denied or incorrectly paid insurance claims. This authorization remains in effect until withdrawn by me.

X Signature:____ Date______________

Authorization to Discuss Your Information with Family or Caregivers

To comply with HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including family, children, caregivers, etc… By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

(Please list anyone you give permission for us to speak with and/or allow to pick up glasses/contacts etc.)

Name: ____________________________ Relationship: ______________ Ph: ______________

Name: ____________________________ Relationship: ______________ Ph: ______________

Name: ____________________________ Relationship: ______________ Ph: ______________

Name: ____________________________ Relationship: ______________ Ph: ______________

X Signature:____ Date______________