

NEWMAN SHIUE, O.D.

727 Silver Spur Rd, Ste. 105 Rolling Hills Estates, CA 90274
Phone: 310-541-3779 Fax: 310-541-0274

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Patient Signature _____ Date _____

Print Name _____ Date _____

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

SIGNATURE ON FILE FORM

Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

Financial Responsibility

By signing this statement you agree to be financially responsible for all charges.

Authorization to release medical information

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine 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 as valid as the original.

Patient Signature _____ Date _____