INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Roberts-Philpott Eye Associates, on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature _____ Date _____

Print Patient Name _____

ACKNOWLEDGEMENT OF RECEIPT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes those uses and disclosures in detail.

I acknowledge that I have received the ***Notice of Privacy Practices*** from Roberts-Philpott Eye Associates.

Patient Signature _____ Date _____

Print Patient Name _____

Legal Guardian/Representative _____ Relationship _____

PERMISSION TO RELEASE INFORMATION

I give permission for Roberts-Philpott Eye Associates to release my Protected Health Information (PHI) to the following people, if requested by such:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____