Whitehead Eye Care PLLC dba Vision Source Kerrville

708 Hill Country Dr., Suite 100 Kerrville, TX 78028

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

- The law requires that Vision Source makes every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Initial *ONE* choice below:

____ I was given the opportunity to read, have read or had explained to me Vision Source's Notice of Privacy Practice prior to any services offered.

____ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

- I authorize Vision Source to release my personal health information to the following individual(s)
  _____
  _____

ACKNOWLEDGEMENT OF THE USE OF STANDARD EMAIL

- Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy. Vision Source also offers you access to your medical records and prescriptions through your secure patient portal.

Initial *ONE* choice below:

____ I authorize the use of standard email to communicate with me as well as send my glasses/contact prescription when I request it, in spite of the known risk.

____ I authorize the use of standard email to communicate with me in spite of the known risk involved.

____ I *do not* authorize the use of standard email to communicate with me. By selecting this option, I realize that I will not have access to my patient portal.

- **EMAIL ADDRESS:** _____

ACKNOWLEDGEMENT OF PAYMENT POLICY

Examination fees, co-payments, and non-covered tests or materials are due at the time of service. If we are a provider for your insurance and you have coverage for services and/or materials, we will submit claim(s) for you. You agree to authorize the release of any medical information necessary to process claims and authorize payment of benefits to Vision Source for services and/or materials as outlined on medical/vision claims submitted by our office. If there is incorrect or insufficient information provided by the patient or guardian, you will be billed our usual and customary fees and provided with a receipt so that you may file the claim yourself. Our office will send one courtesy invoice and payment is expected within 30 days of receipt. If any additional invoices must be sent due to lack of payment, your account will be assessed a $10 administrative fee per invoice. Any account that has not been paid within 90 days from the original invoice date may be turned over to a third-party collection service. You assume all legal fees and service charges incurred if collection action must be taken. Returned checks will be charged a $30 service fee.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

- If you are signing as a personal representative of the patient, please indicate your relationship.
- If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____

Patient/Representative Signature | Printed Name of Patient

_____ _____ _____

Printed Name of Representative | Relationship to Patient | DATE