Patient Name: ____ **Date of Birth:** ______________________________

Acknowledgement of Receipt of Notice of Privacy for Cimarron Family Vision Center

I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices of Cimarron Family Vision Center (the "Practice"). I also understand that the Practice has the right to change its Notice of Privacy Practices and that this updated information is on the company website (cimarronfamilyvision.net/) and that I may contact the Practice at any time to obtain a current copy of its Notice of Privacy Practices.

____

Signature (Patient, Legal Guardian, Personal Representative)

____ _________________________________

Print Name and Relationship (if not Patient) Date

Authorization for Use and Disclosure of Personal Health Information for Cimarron Family Vision Center

I hereby authorize Cimarron Family Vision Center (the "Practice") to use and disclose my medical and financial information with the person(s) identified below. It is at my request, that the specific information that may be used and disclosed to this person(s), includes any and all of my personal health information in the records of Practice that pertain to me.

____ _____________________________________

Name Relationship

____ _____________________________________

Name Relationship

____ _____________________________________

Name Relationship

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of _________________________.

I understand that:

- It is my responsibility to inform the Practice of any desired change in this Authorization.
- I have the right to revoke this Authorization at any time by alerting the Privacy Officer, in writing, at 6602 E Carondelet Dr. Tucson, AZ 85710 or at visiontherapy@live.com, except to the extent the Practice has taken action in reliance of this Authorization prior to receipt of my revocation,
- I have the right to refuse to sign this Authorization. The Practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my authorization.
- The person(s) I authorize may not be governed by privacy laws, therefore, information disclosed pursuant to this Authorization may be subject to re-disclosure and the recipient may no longer be protected by federal privacy law.

____

Signature (Patient, Legal Guardian, Personal Representative)

____ _________________________________

Print Name and Relationship (if not Patient) Date

Patient Name: ____ **Date of Birth:** ______________________________

Insurance

☐ **Patient does not have insurance (Self pay)**

Are you a Medicare Part B beneficiary?
(Circle Yes or No and read the agreement below)

No	Yes
To the best of my knowledge, I am not a Medicare Part B beneficiary. If in the future I became a beneficiary, I will be responsible for alerting Cimarron family Vision Center and completing this contract as soon as possible.	I have read the Medicare Agreement form, and been given the option of obtaining a copy. I understand that Cimarron Family Vision Center has opted out of the Medicare program effective on May 18, 2016 and that I cannot use my Medicare benefits for reimbursement of any services rendered. The Patient, or the patient's guardian, is responsible for any payments to the physician at the time services are rendered.

Primary Vision Insurance

Plan: ____

Member ID: ________________________________

Primary Member: ____________________________

DOB: ___________ / ____________ / ____________

SSN: ____

Patient Relation: ______________________________

Primary Medical Insurance

Plan: ____

Member ID: ________________________________

Primary Member: ____________________________

DOB: ___________ / ____________ / ____________

SSN: ____

Patient Relation: ______________________________

Secondary Vision Insurance

Plan: ____

Member ID: ________________________________

Primary Member: ____________________________

DOB: ___________ / ____________ / ____________

SSN: ____

Patient Relation: ______________________________

Secondary Medical Insurance

Plan: ____

Member ID: ________________________________

Primary Member: ____________________________

DOB: ___________ / ____________ / ____________

SSN: ____

Patient Relation: ______________________________

____

____
Signature (Patient, Legal Guardian, Personal Representative)

____
Print Name and Relationship (if not Patient)

____
Date