Milam's Community Eyecare

805A Commerce Drive • Conyers, GA 30094 • 770-483-4831

Receipt of Notice of Privacy Practices / Release of Medical Info
Written Acknowledgement Form / Financial Policy

I, _____ , have reviewed/received a copy of **Milam's Community Eyecare**'s Notice of Privacy Practices.
Patient Name Practice Name

Insurance Benefits:

_____ I authorize Milam's Community Eyecare to furnish information concerning my visit to my insurance carrier and assign to the provider all insurance payments for medical/vision services rendered on my behalf.

_____ I understand that verification of insurance eligibility and benefits is not a guarantee of payment, and that payment of insurance benefits is determined only when the claim is processed by the insurance carrier. I agree to assume financial responsibility for all co-payments, coinsurance, deductibles, denied, or non-covered services.

Financial Responsibility:

_____ I understand all accounts are full responsibility of the patient and/or the patient's responsible party/guarantor. In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection to this account or future outstanding accounts.

Patient's Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: