

**HIPAA Acknowledgement of Receipt**

I acknowledge that I received a copy of Children's and Family Eyecare's Notice of Privacy Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Insurances accepted:**

VSP \* Blue Cross/Blue Shield \* Eyemed

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**INSURANCE AUTHORIZATION**

I request that payment for authorized Insurance benefits for any services furnished me, be made on my behalf to: Children's Eyecare, P.C.

I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X \_\_\_\_\_

Date \_\_\_\_\_

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**Please provide the following Member Insurance Information:**

Member's Name: \_\_\_\_\_

Member's ID#: \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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