NOTICE OF PRIVACY POLICY

This form is posted in the office and we will gladly provide you with a copy of this notice if you would like to keep one for your personal records. This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Examples of uses of your health record information include patient recall, prescription verification or request, and for co-management with another health professional. Signing below indicates that you have been made aware of our privacy practices.

FINANCIAL ARRANGEMENTS

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Fort Wayne Vision Associates. All co-pays and non-covered services are due at the time of the appointment. Benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for payment of any remaining fees owed.

Thank you for choosing us as your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. If you have any questions about the form, please do not hesitate to ask.

Signature: _____ Date:_____