Vision Source Friendswood

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Vision Source Friendswood Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

I acknowledge that I have been given the following options related to communicating with Vision Source Friendswood, its doctors and staff members:

I agree to allow Vision Source Friendswood doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Vision Source Friendswood. I understand that clinical information will not be part of this message.

Please circle one of the following:

Yes, I agree **No, I do not agree**

I agree to allow Vision Source Friendswood to send me marketing materials/ clinical information concerning services and/or products available at Vision Source Friendswood. Such information will be mailed, e-mailed and/or otherwise delivered in an envelope, post card, container, or electronic communication method that that may contain my name and that of Vision Source Friendswood and/or an individual optometrist or ophthalmologist providing care at Vision Source Friendswood.

Please circle one of the following:

Yes, I agree **No I do not agree**

Assignment & Release/Services & Materials Rendered: I hereby authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for non-covered services. I authorize the physician to release information required to process this claim. I also acknowledge that if I am not using insurance benefits, payment is expected in full at time of services and/or materials rendered.

Signature of responsible party: _____