BLUEGRASS FAMILY VISION

# SIGNATURE ON FILE FOR INSURANCE

This document gives a record that you are aware that we will be filing a claim with you insurance company (medical/vision) for your examination today. In the event that they do not pay you will be responsible for todays bill. Some reaseons they may not pay include but are not limited to

- Non-covered service
- Deductable not met
- Copay or co-insurance

Please rest assured that our relationship is with you the patient and that any care provided to you by our doctor is based on his medical decision, not what your insurance will pay for. Our relationship is with you **NOT** the insurance company. We will be happy to assist you with any billing questions to assure that you are getting the most out of your insurance benefit.

Signed _____ Date _____

# HIPAA NOTICE

Signing below indicates you were offered a chance to review our notice of privacy practices regarding your rights under the federal HIPAA laws. If you would like a copy to keep please ask and we will be happy to provide you with one.

ACKNOWLEDGEMENT OF RECIEPT

I acknowledge that I received a copy of S Chris Mayes OD's Notice of Privacy Practices

Signed_____ Date_____

Patient Name(print)_____