Chester Family
Eye Care

ACKNOWLEDGEMENT OF PRIVACY PRACTICES and FINANCIAL AGREEMENT

By signing, I agree that I have read, either online or in the office, or had explained to me, Chester Family Eye Care LLC Notice of HIPAA Privacy Practice and agree to continue my care with Chester Family Eye Care under said terms.

Additionally, I have read and accept the financial statement either online or in the office.

Payment is expected at the time services are rendered, including non-covered portions of insurance. Please note: most policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. While we do call insurance companies to receive benefit information, we cannot guarantee the accuracy of the information provided. Please understand that financial responsibility for your account is ultimately yours, not that of your insurance company. We are pleased to be able to provide the service of filing your insurance and will forward a bill of any unpaid benefits should there be any.

Please list anyone authorized to access your personal record set (prescriptions, accounts, medical history etc...)

Name: _____DOB_____Relation_____

Name: _____DOB_____Relation_____

Name: _____DOB_____Relation_____

I HAVE READ AND UNDERSTAND THE CHESTER FAMILY EYE CARE LLC HIPAA PRIVACY AGREEMENT AND FINANCIAL STATEMENT AND AGREE TO THE TERMS. I AUTHORIZE THE PERSON(S) LISTED TO ACCESS MY DESIGNATED RECORD SET UNLESS OTHERWISE NOTIFED IN WRITING THAT THEY ARE NO LONGER ALLOWED ACCESS.

Patient/Legal Guardian Sig: _____ Date: ____/ ___/ _____