

PRIVACY PRACTICES ACKNOWLEDGEMENT

Classic Vision Care
1615 Ridenour Boulevard, Suite 201
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Telephone (770) 499-2020

HIPPA ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I certify that I have read and understand the Medical History and have provided answers to the listed questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependant during the period of the exam to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I agree to be responsible for payment of all services or products rendered on my behalf or my dependants that exceeds the amount that my insurance allows.

Name _____ Birth Date _____

Signature _____ Date _____

VISUAL FIELDS TESTING AUTHORIZATION

I hereby authorize Classic Vision Care to conduct diagnostic testing for myself or for the patient for whom I am the parent or legally authorized representative. The cost of the screening would add an additional **\$20.00** charge to your balance if your insurance does not cover it.

I understand that Classic Vision Care will share patient health information according to federal and state law for treatment, payment, and operations. I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. This test is not generally covered by standard vision insurance plans. The Visual Fields Test is recommended by the doctors at Classic Vision Care, it is used to help screen for glaucoma, macular diseases, peripheral retinal disease, and other conditions.

- I AGREE TO** have my retinal health evaluated with the Visual Fields Testing.
- I DO NOT** wish to have the Visual Fields Testing.
I understand that I will still have a thorough eye examination with slit lamp observation.

Patient/Guardian Signature

Date

FUNDUS EYESCREEN AUTHORIZATION

The cost of the screening would add an additional **\$35.00** charge to your balance if your insurance does not cover it.

- I AGREE TO** have my retinal health evaluated with the EyeScreen Exam.
- I DO NOT** wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

Patient/Guardian Signature

Date