*Computer Users: Download & open in Acrobat before filling out **Phone Users: Download Adobe Acrobat Reader app

PATIENT INFORMATION

NAME:
ADDRESS:
DATE OF BIRTH:

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY POLICY

I understand my information will not be released without my prior consent according to the Notice of Privacy Practices for this office.

____ _______________

Patient Signature (or guardian)   Date

INSURANCE AUTHORIZATION

- I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Des Moines Eye Care.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.
- I understand that I am responsible for charges not paid by the insurance plan.

____ _______________

Patient Signature (or guardian)   Date