12280 State Route 30
Irwin, PA 15642

Notice of Privacy Acknowledgement
Assignment of Benefits Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved, directly and indirectly
- Obtain payments from third parties
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description and the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do, then you are bound to abide by such restrictions.

Patient Name ______________________________

Signature ______________________________

Relationship to Patient ____________________

Assignment of Benefits

I hereby assign all medical benefits to which I am entitled to The Sight Center NH. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health plan, to issue payment checks directly to The Sight Center NH for eye care services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize The Sight Center NH to (1) release any information necessary to insurance carriers regarding my treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by both parties.

I have requested services from The Sight Center NH on behalf of myself and/or my dependents, and understand that by making this request I become fully responsible for any and all charges incurred.

______________________________ ____________________

Patient/Responsible Party **Date**