INSURANCE INFORMATION Patient Name_____

Please complete the following information and include the policy holder information only if the patient is not the primary holder.

MEDICAL CARD

Medical Insurance Name_____ ID number_____
(please give the receptionist copies of all cards)

(if different than patient) Policy Holder Policy
Policy Holder Name_____ Birthdate_____ Holder SS#_____

VISION CARD

Vision Insurance Name_____ ID number_____
(please give the receptionist copies of all cards)

(if different than patient) Policy Holder Policy
Policy Holder Name_____ Birthdate_____ Holder SS#_____

I understand that insurance coverage is not a guarantee of payment. I understand that I am completely liable to pay in full for any amount not paid by my insurance company.

_____ _____
(patient or representative signature) **(date)**

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Hilltop Eyecare PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Hilltop Eyecare PLLC's Notice of Privacy Practice and agree to continue my care with Hilltop Eyecare PLLC under said terms.
- ☐ I was given to opportunity to read Hilltop Eyecare PLLC's Notice of Privacy Practices and declined but wish to continue my care with Hilltop Eyecare PLLC under the terms of Hilltop Eyecare PLLC's privacy policies.
- ☐ I have read or had explained to me Hilltop Eyecare PLLC's Notice of Privacy Practice and do not wish to continue my care with Hilltop Eyecare PLLC under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as
  _____
  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient