Shillington Eye Associates
453 East Lancaster Avenue, Shillington, Pa 19607
(610) 775-3321

Financial Policy Acknowledgment Form

I understand that regardless of insurance coverage, I will receive a statement for any balance due after appropriate insurance processing and am financially responsible for all charges including any co-payments, deductibles, non-covered or denied services or any charge not paid by the insurance company.

I have read and understand the Financial Policy for Shillington Eye Associates and agree to the content. I also understand that the policy is subject to change at any time at the discretion of management, formally or informally, either verbally or in writing.

Patient Signature_____ Date_____

Patient Representative Signature_____ Relation_____

Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that I have received/refused a copy of the Shillington Eye Associates Notice of Privacy Practices. I understand that I am to review the policy and any questions or comments related to the Notice of Privacy Practices policy should be directed to the office manager.

Patient Name (Print)_____ Date_____

Patient/Patient Representative Signature_____

Patient Representative's Relationship to Patient_____ Employee Initials_____

Office staff is allowed
____ Call the listed home phone number
____ Call the listed work phone in case of an emergency
____ Leave a message pertaining to medical care with anyone who answers the phone
____ Leave a message on voicemail/answering machine pertaining to medical care

I hereby authorize the release of all clinical, medical and or demographic information to:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____