BILLINGS FAMILY EYECARE, PC

1540 Lake Elmo Drive, Suite 1
Billings, MT 59105

Phone 406-245-2299
Fax 406-245-8302

April 14, 2003

## Notice of Receipt of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____

Date:_____

## Signature On File

I also authorize the insurance company to make payment directly to Billings Family Eyecare, PC. In the event the expected amount is partially paid or not paid at all, I will be responsible to pay the outstanding balance.

1. I authorize use of this form on all my insurance submissions.
2. I authorize release of information to all my insurance companies.
3. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
4. I authorize payment direct to my doctor.
5. I permit a copy of this authorization to be used in place of the original.

Signature:_____

Date:_____