1686 Shiloh Road STE 3
Billings, MT 59106
**P:** (406) 245-2436 **F:** (406) 281-8805

1540 Lake Elmo Dr. STE 1
Billings, MT 59105
**P:** (406) 245-2299 **F:** (406) 245-8302

**DR. JENNIFER CROSS** **DR. STEPHANIE SHOULTS** **DR. DEVIN DESPAIN** **DR. CRYSTAL CARRINGTON-HELLIER**

# 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: _____

**Signature on File**

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

1. I authorize the use of this form on all my insurance submissions
2. I authorize the 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: _____