Acknowledgement of Privacy Practices and Office Polices

The law requires that Palm Beach Eyes of Boynton Beach make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Please check the ONE box that applies:

☐ *I was given the opportunity and declined to read Palm Beach Eyes of Boynton Beach's Notice of Privacy Practices but wish to continue my care with Palm Beach Eyes of Boynton Beach under the terms of Palm Beach Eyes of Boynton Beach's privacy policies.*

☐ *I have read Palm Beach Eyes of Boynton Beach's Notice of Privacy Practice prior to any services offered and agree to continue my care with Palm Beach Eyes of Boynton Beach under said terms.*

☐ *I do not wish to continue my care with Palm Beach Eyes of Boynton Beach. I have read prior to any services offered Palm Beach Eyes of Boynton Beach 's Notice of Privacy Practice and have decided not to continue my care with Palm Beach Eyes of Boynton Beach under said terms.*

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent in order for any third-party payer to pay directly to Palm Beach Eyes of Boynton Beach, Greg Pientka O.D. P.A., and/or his associates insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges, whether paid by my insurance carrier or rendered on my behalf/ dependents. I agree to pay a minimum collection fee of $30.00 and attorney fees if I do not satisfy payment for services rendered. I authorize the use of this signature on all insurance submissions. I acknowledge that I have received a copy of Greg Pientka O.D. P.A. "Notice of Privacy Practices". I understand that I have the right to request my printed prescription for both glasses and contacts. I recognize payment is due in full today and includes exam fees as well as the cost of eyeglasses and/or contact lenses before they are ordered. I also acknowledge that I have been informed of the practices 30 day return policy and that I am obligated to pay a return fee of forty percent of the retail cost of all custom items returned.

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

_____ _____

Patient Signature (Parent or Guardian) *Date*

_____ _____

Print Patient Name *Relationship to Patient (if applicable)*