URBAN EYES

Insurance Signature on File

Patient Name: _____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorized my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Urban Eyes, Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent above. If my insurance does not cover any portion of this visit, I further acknowledge that I am responsible for any co-pays and/or payment for services rendered.

_____ ____/____/____

Patient Signature **Date**

Urban Eyes, Inc. HIPAA Patient Record of Disclosures

In general, the Health Insurance Portability and Accountability Act (HIPAA) gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home.

The privacy rule requires that healthcare providers take reasonable steps to insure that your privacy is protected. Urban Eyes, Inc. is HIPAA compliant and will not disclose any private information unless specifically needed and approved by the patient.

As a patient of Urban Eyes, Inc., I have read and grant permission to Urban Eyes, Inc. to contact me by telephone or mail using the information provided as needed. I also authorize the release of information to those entities (lens manufacture, contact lens company, physician consultation) required to provide complete health care. I have read the above agreement and understand the terms.

_____ ____/____/____

Patient Signature/guardian **Date**