Revised 01/11/2022

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The law requires that Hertneky Vision Source make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Hertneky Vision Source's Notice of Privacy Practice and agree to continue my care with Hertneky Vision Source under said terms. (circle one) YES OR NO
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as _____.

I authorize Hertneky Vision Source to release my personal health information to the following individuals:

_____

- Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.
  (circle one) YES OR NO
- I authorize Hertneky Vision Source to contact me by telephone or other media devices for communications needed to monitor my progress to recommended care.
  (circle one) YES OR NO
- Knowing that Hertneky Vision Source will act responsibly and respectfully, I give permission for the use of my Name, Testimonial, or Image/Photograph in publications and advertisements produced by or for the practice now or in the future.
  (circle one) YES OR NO

Financial agreement

Hertneky Vision Source has a 48-hour cancellation policy in order to provide you with personalized attention. Your scheduled appointment is reserved exclusively for you. We understand circumstances arise that may require you to reschedule your appointment and are happy to change an appointment when given at least 48-hours notice. If sufficient notice is not given, you will be charged a $50.00 missed appointment fee.

As a courtesy to our patients we bill your insurance for covered services. I acknowledge that I am responsible for anything that my insurance does not cover or pay for. We will apply to your account a $5.00 re-billing fee at 90 days overdue and each month thereafter until paid in full.

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

_____	_____	_____
Print Patient Name	Signature	Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____	_____	_____
Representative Signature	Relationship to Patient	Other individual(s) authorized