

# PRIVACY PRACTICES ACKNOWLEDGEMENT

## ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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### HAMILTON MILL EYE CARE

Dr. Kurt E. Treu  
Dr. Roger D. Anderson  
Dr. Rupesh Bhakta

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account number: \_\_\_\_\_

**With this waiver I hereby agree to pay Hamilton Mill Eye Care any remaining balance that my insurance plan does not cover. This includes, but is not limited to, any material costs such as frames, lenses, and specialty lenses. This would also include contact lenses and contact lens evaluations.**

**We file your insurance as a courtesy. However, if your insurance has not paid within 60 days, it becomes your responsibility.**

\_\_\_\_\_  
Patient or responsible party

\_\_\_\_\_  
Witness

*All outstanding debts that are not paid within 120 days will be turned over for collection and a 35% collection fee will be added.*