NEW ERA
EYE CARE

PATIENT NAME: _____ DOS: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I received a copy of New Era Eye Care's Notice of Privacy Practices (HIPAA Policy).

Signature: _____ Date: _____

INSURANCE RELEASE and PAYMENT AUTHORIZATION

I, the undersigned, hereby grant permission to release medical information and medical records and authorize payment of benefits to Dr. Brian D. O'Donnell/New Era Eye Care, LLC. I also understand that I am fully responsible for payment of deductibles, copayments, coinsurance, and any charges that are incurred and not covered by insurance.

> **MEDICARE PATIENTS**: "I request that payment of authorized Medicare benefits be made on my behalf to Dr. Brian D. O'Donnell/New Era Eye Care, LLC for any services furnished me by the doctor or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and payment for related services.

Should this account go to collections for non-payment, the patient/guarantor accepts responsibility for all collection/attorney fees.

Guarantor's Signature: _____ Date: _____