**Leverett Eyecare, P.C**.
812 S. Lynnhaven Road, Suite100
Virginia Beach, VA 23452
757.486.2015

## To our patients with Insurance Benefits:

We are committed to providing you with the best possible care. If you have vision or medical insurance, we are happy to help you receive your maximum allowable benefits. We must emphasize that, as vision care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. By signing this statement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and are not paid for by your insurance plan. Payment is due at time of service.

### SIGNATURE ON FILE:

- I authorize the use of this form on all my insurance submissions
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier(s)
- I authorize payment direct to my doctor
- I permit a copy of this authorization to be used in place of the original

**SIGNATURE:**_____ **TODAY'S DATE:** _____

**SIGNATURE IF OTHER THAN PATIENT:**_____ **RELATIONSHIP:**_____

---

## HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. The notice is posted in our facility and a copy will be provided upon request. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only an acknowledgement that you have received/viewed a Notice of our Privacy Practices:

**Print Name**_____ **Signature**_____ **Date** _____