Dr. Michael L. Serrano, O.D. 3128 Clairmont Road , Atlanta, GA 30329
404-296-6000 FAX: 404-296-3600

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Authorization of Privacy

By signing this consent you are giving the provider and office staff permission to use and disclose your health information. Your health information will only be used and disclosed to provide you care and treatment, to bill and collect payment for services provided, and to perform necessary routine office operations.

You have been provided with a copy of our "Notice of Privacy Practices". You will be given a copy of the revised notice with your first office visit following any change. The most current notice is posted in our waiting area and you may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we agree to the restriction we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under this consent. If you choose to revoke this consent , you must do so in writing. This consnet must be signed by the patient and dated.

Authorization of Benefits

New Vision Eye care & Rehabilitation Services requires copies of your insurance cards in order to file your insurance claims. If you have any type of vision plan that provides discounts this must be presented at the time of your visit in order to receive those discounts.

As a courtesy to you, we will file your insurance claims for your vision benefits as designated by the plan of which you state you are a member(if we are allowed). This service will be provided without any additional charge to you. We will also do all that we can to help you receive the maximum benefits allowed by your plan. However, in the event that the Plan Sponsor determines that you are not eligible at the time of the claim, makes determination that you are eligible for a reduced level of coverage, and/or fails to remit payment on your behalf within 45 days of service, you will be responsible for the charges.

I,_____,hereby assign and authorize payment directly to Dr. Michael L. Serrano, O.D. and New Vision Eye Care & Rehabilitation Services the medical/surgical/vision benefits to which I am entitled under my insurance policy(s). I understand that I am financially responsible to said clinic for charges not covered by this assignment.

Accounts which cannot be collected by Dr. Michael L. Serrano, O.D. And /or New Vision Eye Care & Rehabilitation Services after normal in house collection procedures will be referred to a collection

agency, magistrate or attorney for further collections. By my signature below I understand and agree that I will be responsible for all collection fees, up to but not to exceed court costs and attorney fees.

Signature of Patient or Responsible Party:_____

Relationship if not patient :_____

By signing below, I certify that I have received and reviewed the New Vision Eye Care & Rehabilitation Services " Notice of Privacy Practices" and all of my questions have been answered to my satisfaction in a language I can understand.

Patient Printed Name:_____

Patient or Responsible Party Signature :_____

Date:_____

Signature of Legal Respresentative (Parent, Guardian, Attorney) if patient is under age:

_____

Witness:_____