Email Address: ______________________________

Primary Insurance: ______________________________

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Guardian (If under 18): ______________________________

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Marital Status: Single Married Separated Divorced Widowed

I authorize Bernards Eye Care, LLC, Dr Christopher Dente or his office associates to submit insurance claims on my behalf with payment made directly to Bernards Eye Care, LLC or Dr. Christopher Dente. I acknowledge that I am fully aware of the Bernards Eye Care Notice of Privacy Practices. I further understand that I personally will be responsible for any services that are not covered or paid by my insurance company and/or paid within 60 days of the date of visit.

Acknowledgment of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

HIPPA Acknowledgment and Consent:
By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of patient or guardian: ______________________________

Print Name: ______________________________

Date: ______________________________