Pendleton
EYE CENTER
A PROFESSIONAL CORPORATION

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I reviewed and have been offered a copy of this medical practice's Notice of Privacy Practices.

Patient name	Patient signature	Date

IF not signed by the patient, please indicate relationship:
Parent or guardian of minor patient
Guardian or conservator of a patient not competent to sign

Notice of Refraction Policy

Refraction is the test used to determine your best corrected vision and glasses prescription. Most medical insurance plans DO NOT cover the cost of refraction.

I understand that if I request a glasses prescription, I may be required to pay the $45.00 fee.

Patient name	Patient signature	Date

Attention Vision Plan Members

Your Medical Insurance, as well as your Vision Plan may be billed, depending on Doctor's diagnosis.
I understand that if I have a medical diagnosis, my Medical Insurance is primary, and will be billed for the exam. The cost of refraction, if requested, will be billed to my vision plan.

Patient name	Patient signature	Date