Part A **ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I have received the Notice of Privacy Practices and I have been provided sufficient opportunity to review it.

Patient's Name _____ Date of Birth _____

Patient or Guardian's Signature _____ Date _____

If patient is a minor, please print guardian's name. _____

Part B **AUTHORIZATION TO BILL INSURANCE**

I authorize Woldorff Family Optometry, PA, to bill my insurance carrier(s) on my behalf. I ask that my insurance carrier(s) pay authorized benefits to this office for services and materials furnished to me. I understand that my insurance carrier(s) may not cover all services and materials. Such non-covered services and materials are my responsibility to pay when incurred. I authorize Woldorff Family Optometry, PA, to release my medical information to my insurance carrier(s) and their agents in order to process my insurance claims.

Patient or Guardian's Signature_____ Date _____