

**STEPHEN G. HIRT, O.D.
COLUMBUS VISION ASSOCIATES, INC.**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Stephen G. Hirt, O.D.'s ***Notice of Privacy Practices***.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor, **Stephen G. Hirt, O.D.**, to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to **Columbus Vision Associates, Inc.** for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have any other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor, **Stephen G. Hirt, O.D.**, to act as my agent, as above.

Lifetime Patient Signature

Date

There are certain special procedures that may be advisable for more thorough eye health testing, such as retinal photography, threshold visual field testing, corneal pachymetry, and tonometry, among others. These procedures may or may not be covered by your major medical insurance provider; or if you have an annual deductible, these procedures may be counted towards that amount. In either event, I agree to pay for these special procedures, if they are deemed necessary, and if my major medical insurance provider does not cover it (them) and/or if my deductible has not yet been met.

Patient Signature

Date