Acknowledgment of Receipt
"Notice of Privacy Practices" and Financial Policy

I acknowledge that I have been furnished with a copy of Summit Vision Source's (SVS) "Notice of Privacy Practices" document ("Notice"):

> This document informs me of how SVS will use my health information for the purposes of; (a) my treatment, (b) payment for my treatment, and (c) referral to and from other healthcare providers.
>
> The Notice explains in greater detail how SVS may use and share my health information for reasons other than treatment, payment, and healthcare operations.
>
> SVS will also use and share my healthcare information as is required and/or permitted by law.
>
> SVS has appointed a Patient Privacy Officer. If, at any time, you feel that your privacy has not been respected, please advise your patient care professional, who will assure that further investigation is conducted.

I consent to SVS using and disclosing my treatment and evaluation records, and maintained by SVS, strictly for the purposes that are detailed in the "Notice of Privacy Practices".

Finacial Acknowledgment: I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges for services provided to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable fees incurred in such collection efforts by this office or our assignee.

TCPA Acknowledgement: I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via and automated dialing system with live or recorded voice in connection with any of my accounts this office and at any telephone number I have provided as of this date or in the future.

Patient's Legal Name: _____ DOB: _____
(Please Print)

Signature: _____ Date: _____
(Patient or Legal Representative)