Acknowledgement of Receipt of Notice of Privacy Practices

Janet M. Mint, O.D., F.A.A.O
4131 Southside Blvd. #203
Jacksonville, FL 32216
Phone (904) 646-9737
Fax (904) 646-9783

Patient Name: ____

Patient Address: ____

Patient Phone Number: (___) __________

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclose in detail.

I acknowledge that I have received the Notice of Privacy Practices from Dr. Janet M. Mint.

Signature ____ Date ______________________

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient ________________________ Print Name ________________________

Source of Authority: ____

Insurance Authorization

I request that payment of authorized insurance benefits for any services furnished me, be made on behalf to: Dr. Janet M. Mint.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related service.

I understand that I am responsible for charges not paid by the insurance company.

X_________________________________ Date _________________________________