**Southern TN Eye Specialists, Inc.**
**Harold P. Kavoussi, M. D.**
**336 Poplar View Pkwy, Suite 1**
**Collierville, TN 38017**

## ACKNOWLEDGEMENT FORM

**Authorization of Medical Treatment:** I hereby consent and authorize the Physician and any associates of his/her choice to provide medical treatment for the above patient.

**Release of Information:** I hereby authorize the treating physician to release any information required during my treatment to my insurance company.

**Assignment of Benefits:** I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company. I understand that in the event my account becomes 90 days past due, it will be turned over to a collection agency (attorney) and I will be charged an additional 33.3% collection fee.

## Notice of Privacy Practices

Southern TN Eye Specialists may share my medical information with the following:

Name: _____ Phone: _____

Name: _____ Phone: _____

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

**SIGNATURE: _____ DATE: _____**