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SARAH J. PAIKOWSKY, OD
EYESWEST OPTICAL

12801 WEST BELL ROAD, SUITE 139 SURPRISE,
ARIZONA 85378
PHONE: 623-583-0377 FAX: 623-583-0378
EMAIL: EYESWEST@AOL.COM

Contact Person:

Our contact person(s) (other than yourself) for all questions, requests or for further information related to the privacy of your health information is_____

_____

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Scott Fineman, HIPPA Officer at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request in our reception area.

Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eyes West Optical Notice of Privacy Practices.

Date _____ Patient name_____ Signature _____

INSURANCE SIGNATURE ON FILE/ FINANCIAL RESPONSIBILITY

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Sarah J. Paikowsky, OD and/or Eyes West Optical to act as my agent in obtaining payment and I request that payment of the benefits be made either to me or on my behalf to Sarah J. Paikowsky, OD and/or Eyes West Optical for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents as well as to any other insurance coverage needed to determine these benefits. My signature authorizes release of the above medical information to the insurer or agency and authorizes Sarah J. Paikowsky, OD and/or Eyes West Optical to act as my agent. I understand I am responsible for my/ my dependent's charges including any co-pay, co-insurance, denied by insurance charges or those charges applied to a deductible.

Date _____ Lifetime Patient Signature _____

Authorized Representative if applicable_____

We will do our best to help you navigate your insurance benefits.