Neurology First & Coresight Neuro-Ophthalmology LLC
13400 N. Meridian Street, Suite 283, Carmel Indiana 46032
Tel: 317 798 0040 Fax: 1844 232 5030

ACKNOWLEDGMENT

NOTICE OF PRIVACY PRACTICES: I have been offered/presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law, and outlining my rights regarding my health information.

RETURN TO WORK AFTER VISION LOSS: I understand and agree if I need to be released to work with or without restrictions, this can only be done through functional capacity evaluation via occupational therapy such as ATI. I acknowledge insurance will not cover this service.

RETURN TO DRIVE AFTER VISION LOSS: I understand and agree if I need to return to drive at any point in the future, this must be arranged through a certified driving programs such as RHI.
I acknowledge, Insurance will not cover this service.

Only need to sign once at first appointment.

Patient Name/or Authorized Patient's Representative:_____

Signature:_____

Date:_____