

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name _____ Birthdate _____

Signature _____

Date _____

COMMERCE VISION CENTER

**Dr. Kurt E. Treu
Dr. Roger D. Anderson
Dr. Joseph L. Rouw**

Date: _____

Patient Name: _____

Account number: _____

With this waiver I hereby agree to pay Commerce Vision Center any remaining balance that my insurance plan does not cover. This includes, but is not limited to, any material costs such as frames, lenses, and specialty lenses. This would also include contact lenses and contact lens evaluations.

We file your insurance as a courtesy. However, if your insurance has not paid within 60 days, it becomes your responsibility.

Patient or responsible party

Witness

All outstanding debts that are not paid within 120 days will be turned over for collection and a 35% collection fee will be added.