Sacopee Valley Eye Care
91 Maple St.
Cornish, ME 04020
207-625-3700

We are required by the Health Insurance Portability and Accountability Act (HIPAA), to provide you with a copy of our Notice of Privacy Practices.

The law requires you to sign a form that acknowledges your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices describes in detail which health care information, such as diagnosis and medications, we may release or discuss with other providers, insurance companies, pharmacies, etc.

We feel that most of what we have outlined in our Notice of Privacy Practices represents what exchange of information is reasonably needed to provide good care for you.

Please read the following statement and sign below:
I hereby acknowledge that I have received a copy of Sacopee Valley Eye Care's Notice of Privacy Practices and agree to its terms.

Signature _____ **Date**_____

Patient Name: _____ **Date of Birth**_____

Parent/Guardian Name (for minor children): _____

If you have insurance and would like us to submit a claim on your behalf you must review the statements and sign below. A CMS 1500 claim form can be provided for your review.
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or the party who accepts assignment. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the CMS1500 claim form.

Signed_____ **Date**_____