

**Kentucky Pediatric Ophthalmology and Strabismus (KPOS), LLC  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
&  
AUTHORIZATION FOR PAYMENT**

**BY SIGNING BELOW, I ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES.**

**BY SIGNING BELOW, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE TO PARTY WHO ACCEPTS ASSIGNMENT.**

**BY SIGNING BELOW, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO Kentucky Pediatric Ophthalmology and Strabismus (KPOS), LLC FOR SERVICES RENDERED.**

**PATIENT NAME: \_\_\_\_\_  
(PRINTED)**

**SIGNATURE: \_\_\_\_\_  
(PATIENT OR LEGAL GUARDIAN)**

**DATE: \_\_\_\_\_**