Consent Form

Notice of Privacy Practices Patient Acknowledgment

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclsures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes; treatment, payment and health care operations.
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ I received notification that the members at Eye to Eye Optometry will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  The right to complain to this practice and to the secretary of help and human services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its notice of privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices current notice of privacy practices on request.

Patient name _____ DOB ___/___/_____

Signature _____ Date ___/___/_____

Relationship to patient (If signed by a personal representative of patient)

_____

I herby assign all medical benefits, including all major medical benefits to which I am entitled including medicare, private insurance and any other health plans, to eye to eye optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed eye to eye optometry within 60 days, I may be billed, for any services or products that I have received. I understand that I am responsible for the balances due after billing.

Signature _____ Date ___/___/_____