

Receipt of Notice of Privacy Policies & Consent Form

EYECARE EXCELLENCE, PC / JOHN T. SHANK, OD, FAAO/ DAVID J. HOLDGRAFER OD
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In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers / babysitters please indicate that below, so that we may serve you.

By signing below, you authorize the following people to receive information regarding your treatment or care. If you do not want any of your medical information provided to a family member. Please check the line to the "no" response. At a later date, if you wish to add names to the list, please confirm in writing or call our staff.

Spouse: _____ YES _____ NO _____

Parents: _____ YES _____ NO _____

Other: _____ YES _____ NO _____

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the **Notice of Privacy Practices** from EYECARE EXCELLENCE.

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____

FOR OFFICE USE - changes to above authorized by patient over the phone:

Date _____ Staff Initials _____