



Patient Name: _____ DOB: _____

Address: _____ City _____ Zipcode _____

Phone #: _____ Would you like to receive texts? Yes / No

SSN: _____ Email: _____

Emergency Contact Name and #: _____

Primary Dr. Name and #: _____

Parent/ Guardian's Name: _____ DOB: _____

High Blood Pressure? Yes/No Diabetes? Yes/No High Cholesterol? Yes/No

Glaucoma? Yes/No Cataracts? Yes/ No

Patient Rights and Responsibilities

Our **Notice of Privacy** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. **A detailed explanation of Patient Rights is provided on the back** in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The **Patient** understands that it is their **responsibility to notify the doctor or staff** regarding their glasses or contacts prescription within **90 DAYS** of the exam date, in order to receive a prescription, recheck or change. **After 90 DAYS, the Patient will be required to receive a full exam in order to evaluate and change a prescription.**

There may be charges or copays associated with the exam and purchase of glasses or contacts. **Payment is expected at time of service. Insurance eligibility does not guarantee payment** on their part. In the event that the Patient's insurance does not pay for the charges billed, the Patient is responsible for payment. **The Patient recognizes that it is their financial responsibility to pay for services rendered.**

I, _____, have read and understand my rights and responsibilities as they are written here.

Patient Signature or Responsible Party

Date

NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
[45 CFR 164.520]

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices in their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligation with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice has Notification of Privacy Practices and that the patient can review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will cease.

The Practice may condition receipt of treatment upon the execution of this Consent.