1.) HIPAA Privacy

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

During the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose health care information to treat you, to obtain payment for our services and to conduct health care operations involving out 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 out *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow up care from another health care professional. Similarly, the use and disclosure of your health information for purposes of payment include (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* will be updated whenever our privacy practices change. You can get an updated copay here in our office.

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

I, _____/_____/_____, have been presented
Full name **Date of Birth**
with a *Notice or Privacy Policy* at Focus Eye Care and have been offered to keep such Policy for my own records. I have read and understood the paragraphs above. I consent to the use and disclosure of my health information for purpose of treatment, payment, and health care operations.

_____ _____ __/__/____ OR
Signature **Relationship to Patient** **Date**

I refuse to acknowledge receipt of this Policy and understand that even though I refuse to sign it the Provider will still treat me. _____/__/__
Initial Date

2.) Consent to Bill Insurance and Office Policy on Insurance Benefits and Optical Purchases

By signing below, you are authorizing payment of medical benefits to Focus Eye Care and its doctors for services provided at our office. Also, please be advised that if you are using insurance to cover todays visit, this is a contract between you and your insurance company…not Focus Eye Care. All Eyeglasses orders are custom made to your specific prescription and design- orders are started at our lab immediately after purchase- this limits cancellations and/'or exchanges.

_____ _____ /__/__
Signature **Relationship to Patient** **Date**

3.) Authorization to Release Health Information from Focus Eye Care to Family Members or Health Care Providers (required for all diabetic patients):

_____ _____ /__/_____
Name **Relationship to Patient** **Date**

_____ _____ /__/_____
Name Relationship to Patient Date
