Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____

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 operation involving our office.

The ***Notice of Privacy Practices*** that has been made available to you describes these uses and disclosure in detain. You are free to refer to this Notice at any time before you sign this form. As described in this Notice, the use and disclosure of your heath 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***. Even though an insurance plan may be in effect insuring you for services rendered by our office, a final determination of benefits can only be made after a claim has been processed. As a courtesy to you, Elder Eye Care Associates is hereby authorized to submit a claim to your insurance carrier (assuming we participate in your plan); however, you agree to be responsible for any fees left unpaid by the carrier. In the event that an account requires settlement through an outside collection agency, you will be responsible for all costs associated with the collection of the account, including legal fees, if any.

When you sign this 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 been offered a copy of our ***Notice of Privacy Practices***.

You have the right to request us to restrict the use and discloser of your information, but as described in our *Notice* ***of Privacy Practices***, we are not required by law to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us and we will make every effort to honor all reasonable requests. **Our *Notice of Privacy Practices*** describes how to ask for a restriction.

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

_____ _____

Signature Date

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

_____ _____

Relationship to Patient Print Name