HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I have been given the right to review and sign this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ___________________________Signature: ______________________________

Relationship to Patient: ___________________ Date: ______________

Using Insurance?

If we do not participate in your eye care plan we will expect payment from you at time of service although we will file on your behalf, if requested, with your insurer.

If we do participate in your eye care plan we will collect any co-payments or overages at the time of service. We will do our best to verify your insurance benefits and eligibility for services. Sometimes, however, insurance companies do not pay as expected. In this case we will file an appeal on your behalf, but will hold you responsible for the cost of your services and/or eyewear. We will abide with the fee schedule/terms of our contract with your insurer.

I have read and I understand and agree to the terms described above. I request that payment of authorized insurance benefits be made either to me or on my behalf to the Eyecare Center of Leesburg. I authorize the Eyecare Center of Leesburg to release to the appropriate insurance carriers and 3rd party billing agencies any information needed to determine these benefits.

Sign: ____Date: _________________________