PRECISION FAMILY
EYE CARE

Patient Privacy Consent Form

At Precision Family Eye Care, we take the privacy of your personal information very seriously.

Our **Notice of Privacy Practices** 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.

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 most important parts of our Notice of Privacy Practices are outlined below:

- Protected Health information may be disclosed or used for the purpose of treatment, payment, or health care operations.
- Under most other circumstances, prior authorization is required by the patient or guardian to share ANY personal general or health information with another individual, insurance, business, or entity unless expressly outlined in the Notice of Privacy Practices
- The Practice has a Notice of Privacy Practices, and the patient has the opportunity to review this Notice at any time.
- The patient has the right to restrict the use of their information
- The patient has the right to assess their medical records at any time or to obtain copies of such records.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may not condition treatment upon the execution of this Consent.

_____ _____

Name of Patient (Print) Date

_____ _____

Signature of Patient or Representative, include relationship to patient, if applicable. Date

This consent expires 1 year from date of signature.

PRECISION FAMILY EYE CARE

Financial Agreement and Consent to Treatment

_____ _____

Name of Patient (print) Date

1. **FINANCIAL AGREEMENT:** As a patient of **Precision Family Eye Care (PFEC),** I understand that **payment for services is due in full at the time services are rendered**. All materials (glasses, contact lenses, and other physical materials) must be paid in full before products are ordered or dispensed. Because services are based on medical necessity, it is impossible for doctors or staff to provide a total cost prior to evaluation. I understand that PFEC bills my insurance as a courtesy, but this is not a guarantee that my insurance will pay for the services rendered or materials provided. It is my responsibility to know my insurance benefits and coverage. **I am responsible for all copays, deductibles, and services or materials that are not covered by my insurance**. In the unlikely event that it becomes necessary to involve a collection agency and/or legal assistance, I will be responsible for any collection expenses and reasonable associated fees.

2. **NON-COVERED SERVICES:** I understand that PFEC's agreements with health insurance plans (PPOs, HMOs, VCPs) relate only to the items and services which are "covered" by the insurance plan. **I accept full financial responsibility for all items or services which are determined by my insurance not to be covered; this includes the refraction fee for a glasses prescription.**

3. **MEDICAL INSURANCES INCLUDING MEDICARE:** I request that payment of authorized medical insurance benefits be made on my behalf to Precision Family Eye Care for services rendered by PFEC. I authorize any holder of medical information about me to be released to the Centers for Medicare and/or its agents for the purpose of remuneration. I understand my signature requests that payment be made and allow release of medical information to allow the claim to be paid. I understand that I am responsible for any copays, deductibles, coinsurance, or not covered fees as laid out by my insurance plan.

AUTHORIZATION TO BILL: *I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payments directly to Precision Family Eye Care for services and/or materials. I authorize PFEC to release information about me or my dependents necessary to process claims associated with my office visit(s).*

AUTHORIZATION TO TREAT: *I authorize the doctors and staff of Precision Family Eye Care to furnish optometric care and services, including but not limited to, diagnostic testing, examination, and other medical and/or surgical procedures deemed necessary during my care.*

_____ _____

Signature of Patient or Guardian Date

Name: _____ Date of Birth: ____/ /____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

◯ Spouse_____

◯ Child(ren)_____

◯ Other_____

◯ Information is not to be released to anyone.

Messages

◯ home (call)

◯ work (call)

◯ cellular (select preference) □ text □ call □ either

If unable to reach me:

◯ you may leave a detailed message

◯please leave a message asking me to return your call

This Release of Information will remain in effect until terminated by me in writing.

Signed:_____ _____ Date: _____/_____/_____