Las Vegas
FAMILY EYE CARE

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Receipt of Notice of Privacy Policies & Consent Form

Patient Name:

ADDITIONAL NOTICE
RECORDS WILL BE RETAINED
FOR A MINIMUM OF 5 YEARS

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 operations involving our 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 our ***Notice of Privacy Practices***, the use and disclosure of your health 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***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office **(or from our website).**

When you sign this consent 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 received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. 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 purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Las Vegas Family Eye Care.

_____ _____
Signature Date

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

_____ _____
Relationship to Patient Print Name

Source of Authority:_____

Please turn over and complete other side

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WELCOME TO OUR OFFICE

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

PATIENT INFORMATION

Last Name_____ First Name _____ M.I._____ SSN_____

Whom may we thank for referring you to our office? _____

Birth Date_____ Age_____ Sex_____ Marital Status _____

Home Phone_____ Cell Phone_____ Email_____

Address_____ City_____ State_____ Zip_____

Patient Employer_____ Occupation_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Responsible party for payment of your account? _____

Name of vision insurance_____ Name of major medical insurance_____

SPOUSE/PARENT/SECONDARY INSURANCE INFORMATION

Last name _____ First Name _____ M.I._____ Date of birth _____ SSN_____

Address _____ City _____ State _____ Zip _____ Home Phone _____

Employer_____ Insurance_____ Occupation_____ Work Phone _____

Employer address _____ City _____ State _____ Zip_____

Name of vision insurance_____ Name of major medical insurance_____

IF CHILD – OTHER RESPONSIBLE PARENT INFORMATION

Last name _____ First Name _____ M.I._____ Date of birth _____ SSN_____

Address _____ City _____ State _____ Zip _____ Home Phone _____

Employer_____ Insurance_____ Occupation_____ Work Phone _____

Employer address _____ City _____ State _____ Zip_____

Name of vision insurance_____ Name of major medical insurance_____

PLEASE HAVE RECEPTIONIST COPY YOUR INSURANCE CARDS

All Patients Please Sign:

I authorize the doctor to release any information including the diagnosis and the records of any treatment rendered to myself (or my child) during the period of such care to third party payers and/or to other health practitioners. I understand that the doctor is billing my insurance for services rendered, provided that I am eligible for coverage, and that my insurance covers the designated services. I further understand that I must meet all co-pay requirements specified by my insurance company at the completion of my examination. In the event my insurance does not cover the complete cost of all services, I assume full responsibility for payment of any remaining balances.

Signature_____ Date_____

Please turn over and complete other side