HIPAA Compliance Patient Consent Form

Elite Eye Care, PC provides this Consent to comply with the privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Elite Eye Care, PC and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

If you believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Elite Eye Care, PC or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment and referral
- To Obtain payment & file insurance
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care
- For research and education
- To prevent serious threats to health safety
- For workers' compensation programs
- In response to certain requests arising out of lawsuit or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

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. Elite Eye Care, PC may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Elite Eye Care, PC. You hereby grant full authority to the optometrists and their respective assistants to administer and perform all drugs, treatments, tests, or diagnostic procedures to or upon me, which may be advised or necessary.

The information and Notice of Privacy Practices is made available upon request.

Signature and Date:_____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Elite Eye Care, PC to release my records and any information requested to the following individuals.

1.
2.
3.
4.

Signature and Date:_____

INSURANCE CONSENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Elite Eye Care, PC all insurance benefits, if any, otherwise payable to me for the services and/or materials rendered. **I understand that I am financially responsible for all charges whether paid by insurance**. I hereby authorize the optometrist and their respective assistants to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature and Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on behalf to Elite Eye Care, PC for services furnished me by Elite Eye Care, PC. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

Beneficiary Signature and Date:_____

Beneficiary Name:

Contact Lens Prescription Signed Acknowledgment Form

Included below is important information to review prior to receiving your contact lens prescription.

The Centers for Disease Control and Prevention (CDC) makes clear, “Contact lenses can provide many benefits, but they are not risk-free—especially if contact lens wearers don’t practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment.”

The CDC recommends the following for contact lens wearers:

✓ Schedule a visit with your eye doctor at least once a year.

✓ Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.

✓ Understand that eye infections that go untreated can lead to eye damage or even blindness.

The Food and Drug Administration (FDA) indicates:

✓ “To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It’s safer to be re-checked by your eye care professional.”

Symptoms of Eye Infection include:

- Irritated, red eyes
- Worsening pain in or around the eyes—even after contact lens removal
- Light sensitivity
- Sudden blurry vision
- Unusually watery eyes or discharge

Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting.

Patient Signature and Date:_____