Receipt of Notice of Privacy Policies & Consent Form

Professional Eyecare, LLC. 131 Boston Post Road Ste 4, Waterford, CT 06385

Patient Name: ______________________Patient date of birth______________________

Patient Social Security # _________________ Patient phone # ______________________

Patient Address:____

Email Address: ____

In the course of providing service to you, we created, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you or to obtain payment for our services.

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 insures 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.

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 and to obtain payment for our services. You also signify that you have received a copy of our *Notice of Privacy Practices*. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment or payment, 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 or my health information for purposes of treatment and payment. I acknowledge that I have received the *Notice of Privacy Practices* from Professional Opticians, Inc.

______________________________ ______________________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient.

______________________________ ______________________________

Relationship to Patient Print Name