Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my personal health information by **Dr. David Fierce O.D. and Dr. Alfred M. Long Jr. O.D.** for the purpose of diagnosing or to conduct healthcare operations to **the office of Advanced Eye of Marietta**.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of Advanced Eye of Marietta has taken action in reliance on the consent.

My "protected health information" means health information including my demographic information, collected from me and created of received by my physician, another healthcare provider, a health plan, my employer or a healthcare-clearing house. This protected health information related to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information my identify me.

SIGNATURE of Patient or Personal Representative X_____ Date:_____

Printed Name of Patient or Personal Representative X_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES ADVANCED EYE OF MARIETTA

I have reviewed a copy of the NOTICE OF PRIVACY PRACTICES for the office of Advanced Eye of Marietta and understand I may request a copy to have for my records if so desired.

SIGNATURE of Patient or Personal Representative X_____ Date:_____

Printed Name of Patient or Personal Representative X_____

HIPPA PRIVACY REGULATIONS AS OF APRIL 14, 2013

As a healthcare provider, we recognize that it is often necessary for others to help the patient with their healthcare needs. For example, the age of the patient, the mental status of the patient, or the disability of the patent may require assistance. However, with the privacy regulations, it is now necessary for us to have in writing who is about to seek care for a patient, and who we are able to release information to. If at any time, someone other than those designated needs information about a patient, then written permission must be obtained.

Please list the names you would like for our office to have the permission to discuss treatment or any other healthcare needs.

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Notification

As a courtesy to all of our patients, we will bill medical as well as routine vision insurance plans. In many cases, comprehensive vision exams identify medical conditions. When this occurs, your medical insurance carrier must be billed instead of your routine vision plan.

Comprehensive eye health exams always include a refraction, which determines your prescription for glasses. **All major medical plans, including Medicare, deny the charge for the refraction as a "non-covered" procedure.** You will be responsible for your specialist co-pay and the cost of the refraction at the time of service. The cost for refraction is $35.00.

X_____ _____/_____/_____

Patient Signature Date

**********OFFICE USE ONLY**********

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained for the following reason.

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other _____