HIPAA Compliance Patient Consent Form

Updated 04/15/2025

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment up on execution of this consent.

PATIENT:_____ Date of Birth ____/____/_____ **Phone #**_____

Mailing Address_____ City_____ St_____ Zip_____

E-Mail Address_____ **Social Security Number**_____

I authorize the release of my health information, including the diagnosis, records, examination, and prescription information, or materials (including glasses & contacts). This information may be released to the following people:

_____ Patient's mother: Phone:_____

_____ Patient's father Phone:_____

_____ Spouse Phone:_____

_____ Children Phone:_____

_____ Other Phone:_____

This release of information will be in effect until terminated by me in writing or until a new form is filled out.

You may release my glasses and/or contact lenses to the above contacts OR to ANYONE that I have sent to pick them up.

I will call to verbally add anyone that is NOT listed above to pick up PRESCRIPTIONS for Glasses, Contact Lens, Medication or any Protected Health Information, in the event I am unable to. I give permission to add that person to my HIPAA.

You can leave a message/ voicemail or try contacting me through the contacts above if unable to reach me.

[ ] My information is NOT to be released to anyone. (Including picking up glasses/contacts, prescriptions or any other Protected Health Information.)

Signature_____ DATE_____

Guardian's Signature (If under 18) _____

*PLEASE TURN OVER AND COMPLETE THE BACK OF THIS PAGE ALSO

GLENWOOD
Eye Care

Updated 04/15/2025

Effective April 20, 2020, all exam services MUST be paid IN FULL at the time services are rendered.

At Glenwood Eye Care, we provide comprehensive eye exams. In addition to a comprehensive eye exam, we offer a visual photograph that can be taken by our ocular camera. The photo captures many vital components of the posterior part of the eye, such as the retina, macula, and the optic nerve.

This is not a requirement for a comprehensive eye health exam, but it is a service we provide to educate our patients on their ocular health. It allows the optometric physician to explain the ocular health with a visual. It is not a substitute for dilation.

_____ I would like to have retinal photos taken. (This service is not covered by insurance. It is an additional $19.99.)
_____ I do not want to have retinal photos taken.

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payments. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Insurance Filing

As a courtesy to our patients, we are happy to file insurance for you. You must understand and agree that (regardless of insurance status), YOU are responsible for account. It is your responsibly to give us your current insurance information. By signing below, you agree to this statement.

Acknowledgement of Notice of Privacy Practices (NPP)

Please mark one below:

_____ Yes, I have read or had explained to me by this office the NPP and I wish to continue my care under said terms.

_____No, I have not read this office's NPP but was given the opportunity to read it and declined. I wish to continue my care under said terms.

_____The NPP could not be read due to the emergent nature of the care needed.

I understand that full payment is due at the time of services rendered.

****A $25.00 fee will be added to all returned checks.**

**** A $25.00 NO SHOW fee will be charged for any appointments that are not canceled or rescheduled.**

****I understand there is a $25 service fee <u>for verifying</u> all prescription lenses filled outside of our optical.**

Signature agreeing to all above terms: _____ Date _____

TURN OVER AND COMPLETE OTHER SIDE ALSO