

Patient Consent Form**Privacy Rule (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provided the minimum necessary information to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not the patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our patients), to request and revoke consent in writing.

Consent for Photographs and Videos

I give permission for the East Bay Ophthalmology to take photographs and/or videos for medical treatment, insurance authorization, educational purposes, or any other purposes in the necessary work of the organization.

Consent for Medication History

I give permission for the East Bay Ophthalmology to obtain medication history for clinical use only.

Consent for Refraction

Refraction is a procedure that determines the prescription for eyeglasses or contact lenses. We can bill your insurance for this procedure, but if it is denied, I understand that I am responsible for the **\$50.00** cost of this procedure. I understand that I can choose not to be refracted as well.

Consent to Cancellation Fee

I understand that I am responsible for a \$20 fee for appointments cancelled or rescheduled within 24 hours.

Consent for Insurance Authorization

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Dr. Lee for any services furnished to me by them. I authorize any holder of medical information about me to release to the health care financing administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Consent for Financial Responsibility

I understand that I am financially responsible for all charges whether or not paid by the insurance. I understand that any claims that are denied or left unpaid after 3 months will be patient responsibility and any patient with recurring denials will be considered cash payment upfront and will be reimbursed if and when the insurance pays.

Your signature below acknowledges your understanding of the Privacy Rule, Consent for Photographs and Videos, Consent for Refraction, Consent for Medication History and Consent for Financial Responsibility.

 Print Name

 Date

 Signature