Optometric Associates

117 WEST MAIN STREET NEW HOLLAND, PA 17557 T(717) 354-2020 F(717) 355-2020

HIPAA INFORMATION AND CONSENT

This Acknowledgement of Notice and Consent authorizes Optometric Associates to use and disclose health information about you for treatment, payment, and health care operations purposes.

1.) Please list the family member or other persons, if any, who may be informed about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Access granted to:_____ Relationship:_____

2.) Please list the family members or significant others, if any, who may be informed about your medical condition ONLY IN AN EMERGENCY SITUATION:

Name: _____ Phone Number: _____

3.) Please print the telephone number where you want to receive calls about your appointments, lab and imaging results, or other health care information if other than your home phone number.

Contact telephone (with area code): _____

4.) Can confidential messages (i.e. appointment reminders, lab and imaging results, testing information) be left on your telephone answering machine or voicemail? Check here please: **[ ] Yes [ ] No**

Optometric Associates presents all of our patients with their rights and responsibilities with the expectation that observance of patient rights will contribute to more effective patient care and greater satisfaction for the patient, the doctor and the clinical organization. If you would like to review what your rights are as a patient, you may review or obtain a written copy prior to signing this acknowledgment and consent.

Furthermore, Optometric Associates expects that they will be supported by the clinic on behalf of its patients, as an integral part of patient care. A personal relationship between the doctor and the patient is essential for the delivery structure. We present your responsibilities as a patient below.

Statement of Patient Responsibilities:

Optometric Associates believes that the best healthcare results from a real partnership between patients and their caregivers. Your responsibilities as a patient involve you actively being involved in your care. This includes:

1. Provide to the best of his/her ability, accurate, and complete information about present complaints, past conditions, medications, unexpected changes in conditions, and other matters pertinent to his/her health.

2. Understand and follow the treatment plan recommended by the provider or ask questions and discuss concerns with the provider when he/she does not understand or agree with the plan of treatment

3. Pay attention to your medications.

   3.1. Tell your doctors or nurses about any allergies or serious problems you have with a medicine.

   3.2. Be sure you understand what the medicine is for and how you are supposed to take it.

   3.3. When you pick up your medicine, check the bottle; be sure it has your name on it. If you've taken the medicine before, make sure it looks the same.

4. If in doubt, ask a question.

5. Keep appointments reliably and promptly or notify Optometric Associates when unable to do so, calling 24-36 hours in advance or at your earliest convenience.

6. Fulfill financial obligations for his/her care in a timely manner (pay your bill).

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7. Be respectful of others while at Optometric Associates. Cell phones must be turned off throughout patient care areas due to HIPAA laws. Cell phone conversations and messaging must be conducted outside of the practice limits.

8. If you have a test; don't assume no news is good news. Ask for the results if you aren't contacted by your doctor or staff.

Notice of Privacy Practices: Optometric Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your Protected Health Information (PHI) and exercise other rights concerning your protected health information. *You may ask to review our current notice prior to signing this acknowledgement and consent.* You may also request a written copy of our notice. By signing this consent:

I consent to treatment necessary for the care of the patient named below.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of all medical records, if necessary.

I authorize Optometric Associates to use photos or information concerning my case in the interest of medical education, and I understand that I will not be identified by name or other protected information.

I acknowledge that I am responsible for payment at the time of each visit for all services rendered by Optometric Associates which are not covered by an assigned insurance or agency authorization or for which no prior payment arrangement has been made.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

We reserve the right, without prior notification, to change our Notice of Privacy Practices and to make the terms of any change effective for all PHI data that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a request to our Privacy Officer in writing at:

–> Optometric Associates
ATTN: Privacy Officer
117 West Main Street
New Holland PA 17557

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, AND INSURANCE AUTHORIZATION. I ACCEPT ON BEHALF OF MYSELF AND/OR THE PATIENT UNDER CARE ALL THE ITEMS LISTED ABOVE IN THIS NOTICE GIVEN BY OPTOMETRIC ASSOCIATES.

Patient Signature: _____ Date:_____

Print Name: _____

Witness: _____ Title: _____

If patient is a minor or unable to sign, complete the following:

Guardian Signature: _____ Date:_____

Relationship: _____

Witness: _____ Title: _____