DRS. FACTOR & LANG
Optometry
4550 East Bell Road, #104
Phoenix, AZ 85032

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment and authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges they were offered a copy of the current Notice of Privacy Practices for this healthcare facility. A copy of this signed and dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs to be sent to another attending doctor or facility in the future. By signing this HIPAA Patient Acknowledgment Form, I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. We, Drs. Factor & Lang Optometry, under current HIPAA Omnibus Rule, will provide the patient with this information with the patient's knowledge and consent.

Patient Name Printed: ______________________ Date Signed: ____________

Patient Signature: ____________________ Preferred Name: ____________________

If Patient is a minor

Parent/Legal Guardian Signature: ____________________ Relationship: ____________

CONFIRMATION TREATMENT AND BILLING COMMUNICATION

Please select your preferred method(s) of contact regarding your upcoming appointments, glasses/sunglasses and contact lens pickup and accounting matters.

METHOD	LIST YOUR CONTACT INFORMATION BELOW
❑ Home Phone	____________________
❑ Cell Phone	____________________
❑ Work Phone	____________________
❑ Text Message	____________________
❑ Email Address	____________________

CONSENT TO RELEASE HEALTH INFORMATION

If you want someone else to have access to your private health information, you must give us permission by listing the person(s) name and relationship below. Your information will not be released without your written consent.

Name	Relationship	Phone Number

❑ I do not want anyone to have access to my private health information.