ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

1202 Troy-Schenectady Road
Latham, NY 12110
Telephone: (518) 374-8001

Welcome to our office,

You will soon be coming for a full Vision Rehabilitation Analysis. This includes testing for light sensitivity, balance, coordination, visual fields, and many other vision problems. Dr. Fox will be assessing your eye focusing, eye tracking, eye coordination, acuity, eye health and some visual perceptual abilities.

Enclosed you will find our new patient forms that need to be returned to our office **prior to your scheduled appointment**. Please use the enclosed envelope, or fax to our office at 518-374-5923.

The initial evaluation with Dr. Fox is an hour long appointment. This will allow enough time for a comprehensive vision evaluation as well as additional time to address your questions and concerns. The fee for this appointment is $280.00. This fee includes one initial report, if requested by the patient.

We look forward to the opportunity to improve your quality of life through your visual system.

Sincerely,

Robert S. Fox, O.D.
Fellow College of Optometric Vision Development

ROBERT S. FOX, O.D., F.C.O.V.D.

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VISION REHABILITATION QUESTIONNAIRE

***Please fill out this questionnaire carefully* prior to your appointment.**

GENERAL INFORMATION

Patient Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
Email: _____
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If yes, who is the carrier? _____ Policy #: _____
Does the insurance cover eye examinations or glasses? Yes ☐ No ☐
Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____
Social Security Number: _____ Driver's License No.: _____
What is your occupation? _____ Employer: _____
Business Address: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Phone #: _____
Business Address: _____

MEDICAL HISTORY

Date of injury/accident: _____
Type of injury/accident: Motor vehicle ☐ Fall ☐ Blow to head ☐ Industrial Accident ☐
Medication-related ☐ Drug abuse ☐ Poison or toxic substance ☐ Carbon dioxide ☐
Drowning ☐ Cord around neck ☐ Stroke ☐ Lyme/Chronic Disease ☐
Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):
Forehead ☐ Right side ☐ Left side ☐ Back of head ☐ Top of head ☐ Face ☐
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____
Did you lose consciousness? Yes ☐ No ☐ If yes, for how long? _____
Were you in a coma? Yes ☐ No ☐ If yes, how long? _____
SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)
Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐ Dizziness ☐
Vomiting ☐ Flashes of light ☐ Disorientation ☐ Loss of balance ☐ Neck pain/whiplash ☐
Loss of memory ☐ Restricted field of view ☐ Restricted motion ☐
Other: _____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury/illness? _____
Name of Doctor: _____ Specialty: _____
Where were you seen? _____Were you hospitalized? Yes ☐ No ☐ How long? ___
What were you and your family told? _____
What did the initial treatments consist of? _____
What prognosis/recommendations were you given? _____
Were you given medications? Yes ☐ No ☐ Medication: _____
For what condition(s)? _____
List any medications, including vitamins and supplements used at the current time: _____
_____

SUBSEQUENT/OTHER PROFESSIONALCARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

Physicians Name: _____ Date: _____
Results and recommendations: _____
Physiatrist Name: _____ Date: _____
Results and recommendations: _____
Neurologist Name: _____ Date: _____
Results and recommendations: _____
Neuropsychologist Name: _____ Date: _____
Results and recommendations: _____
Physical Therapist Name: _____ Date: _____
Results and recommendations: _____
Speech / Language Therapist Name: _____ Date: _____
Results and recommendations: _____
Psychologist / Psychiatrist Name: _____ Date: _____
Results and recommendations: _____
Osteopathic Physicians Name: _____ Date: _____
Results and recommendations: _____
Other / Name: _____ Date: _____
Results and recommendations: _____

Do you have a history of allergies? Yes ☐ No ☐
If yes, please explain: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____
Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____
Has a speech and language evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____ Date: _____
Results: _____

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who
High blood pressure	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid condition	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Brain Tumor	☐	☐	_____
Stroke	☐	☐	_____

	Patient	Family	Who
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Blindness	☐	☐	_____
Strabismus	☐	☐	_____
Amblyopia	☐	☐	_____
Traumatic brain injury	☐	☐	_____
Lyme/Tick-borne disease	☐	☐	_____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes ☐ No ☐

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

Were glasses, contact lenses or other optical devices recommended? Yes ☐ No ☐

If yes, what? _____

Are they used? Yes ☐ No ☐ If yes, when? _____

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes ☐ No ☐

If yes, what? _____

Did you undergo these treatments? Yes ☐ No ☐ Explain: _____

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Eyes ache	☐	☐	☐
Eyes pull or tug	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Eyes twitch	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Motion sickness / car sickness	☐	☐	☐
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of interest/concentration when doing close work	☐	☐	☐
Orient writing/drawing poorly on page	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Hold books too close	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision / Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Difficulty with dressing	☐	☐	☐
Difficulty with bathing / personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion / disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Bothered by noises	☐	☐	☐
Bothered by touch	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐
Difficulty recalling information known in the past	☐	☐	☐
Difficulty remembering formerly familiar people / objects	☐	☐	☐
Difficulty performing tasks formerly			

easy / routine	☐	☐	☐

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Difficulty counting money	☐	☐	☐

Why do you feel the need for a vision evaluation today? _____

_____

_____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes ☐ No ☐

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships): _____

_____

_____

What activities comprise the majority of your daily life since your accident/injury? _____

_____

_____

_____

What activities can you no longer engage in due to your visual or other difficulties? _____

_____

_____

_____

What other changes/limitations in your daily life do you attribute to your accident/injury? _____

_____

_____

_____

What do you hope a Visual Rehabilitation Program can do for you? _____

_____

_____

_____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? _____

If a student, what is the major course of study? _____

How many hours daily are spent at a desk? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent reading/studying? _____

How many hours daily are spent with a computer? _____

Release Of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of FOX VISION DEVEOPLMENT CENTER when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

_____ _____

Signature of patient or authorized representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day /7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Robert S. Fox, O.D., F.C.O.V.D.
Clinical Director

ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

1202 Troy-Schenectady Road
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Telephone: (518) 374-8001

Patient Services Contract

Welcome to our practice! Dr. Fox and his staff are looking forward to building a relationship with you or your child to help you best reach your full visual potential. This document contains important information about our offices professional services and business polices. Please read it carefully and write down any question you might have so they can be discussed. When you sign this document, it will represent an agreement between you and our practice.

CANCELLATION POLICY: We typically have a waiting list of patients who are eager to set up appointments as soon as possible. As such, it is important to keep your appointment for the time it was scheduled. This cancellation policy applies to appointments scheduled with the Doctor. Additional information regarding weekly therapy appointments will be provided and discussed at a later date should the need arise.

- Appointments that are cancelled more than 48 hours in advance will *not* be charged a cancellation.
- Appointments that are cancelled the day prior to your appointment will be subject to a $50.00 cancellation fee. These phone calls must be received prior to 5:00pm.
- Appointments that are cancelled the day of your scheduled appointment will be subject to a $75.00 late cancellation fee. This includes calls that are received after 5:00pm on the previous day.
- If you do not show to your scheduled appointment without a prior phone call, a $90.00 fee is charged.

In these cases your credit or debit card will be charge automatically.

BILLING AND PAYMENTS: You are expected to pay for all visits with the Doctor at the conclusion of each visit. Please refer to the credit/debit card payment agreement form for detailed information about how outstanding balances are charged.

Medicare/Workers Compensation/No fault: The office only participates with 3 different insurances, Medicare (government funded, *not* managed care programs), Workers Compensation, and No-Fault. No payment will be collected at the time of services. Medicare patients - you may receive a bill in the mail from Solutions billing on our behalf to collect your insurance companies determined co-pay for our services. Workers Compensation and No-Fault patients please be aware it is important our office receives payment and you will be asked to speak with your attorney in the event that payments are not received.

INSURANCE REIMBURSEMENT: All other patients seen in our office are expected to pay out of pocket for our services. It is important to coordinate with your health insurance company

to find out if they will reimburse for out of network providers for the services we provide. You will be provided an itemized bill after every visit with the Doctor that has all the information needed to complete most paperwork requests from your insurance company. Itemized receipts will only be provided upon request at the conclusion of each therapy session that has been paid in full. It is important to note that we do not accept any payment from insurance companies, including co-pays for our services; it is you as the patient or guardian to be responsible for the full payment of our fees. Please speak with the Patient Care Coordinator or Vision Therapy Administrator if you need additional services and they can help with whatever information they can based on previous experiences.

CONTACTING THE OFFICE: The Doctor and specific staff members are often not immediately available by phone. Please leave a detailed message with the Patient Care Coordinator so that the appropriate member of the staff can return your call as quickly as possible. Often times the Chief Therapist and Certified Therapists in the office are well equipped to answer most questions, and are more readily available to return phone calls than the Doctor.

EMAIL COMMUNICATIONS: Doctor Fox does not correspond with patients via email. If you wish to correspond with the Vision Therapy Administrator or Vision Therapist an email consent form will be provided to you at the appropriate time. Please note, this is not an acceptable way to cancel or reschedule appointments – that can only be done by calling the office.

TEXT MESSAGES: The office does not correspond via text message regarding any of our patients or scheduled appointments.

SOCIAL MEDIA: The office does has a Facebook page and Instagram. We invite you to check in, follow us, like and share our posts! However, we do not use those platforms to contact you regarding your care. Please, do not contact us via these means to ask us questions, and especially to cancel appointments. Any cancelation of appointments via social media will be counted as a no call/no show appointment and you may be held responsible for a cancelation fee per the previously mentioned policies.

STATEMENT OF RELEASE BY SELF/PARENT/GARDIAN TO INSURANCE COMPANY: I authorize Fox Vision Development to release medical information about myself or my child to the applicable insurance company should any information be needed to determined reimbursement of services. By signing this consent, I acknowledge that I have read it or it has been read to me, that I am at least 18 year old, that I understand the above agreement and that I am singing this consent voluntarily.

_____ _____

Patient/Parent/Guardian Signature Date

ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

1202 Troy-Schenectady Road
Latham, NY 12110
Telephone: (518) 374-8001

Credit Card Authorization Form

Patient Name:_____ DOB:_____

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ❑ MasterCard ❑ VISA ❑ Discover ❑ AMEX ❑ Carecredit ❑ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVC: _____
Expiration Date (mm/yy): _____
Cardholder ZIP code (from credit card billing address): _____

I, _____, authorize Fox Vision Development to keep my signature on file to charge my credit/debit card listed above for outstanding balances 30 days past due, and late cancelation/no show fees due on the account of the patient named above. The card may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. Receipts will be sent upon payment processing to the address indicated below. I may continue to schedule appointment provided my credit card remains on file, is valid and additional fees are not accrued.

_____ _____

Signature Date

Mail Receipts to:
Name: _____
Street Address: _____
City, State, Zip: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - was not created by us, unless the person that created the information is no longer available to make the amendment,
  - is not part of the health information kept by or for us,
  - is not part of the information you would be permitted to inspect or copy, or
  - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

1202 Troy-Schenectady Road
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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date:	Initials:	Reason:

ROBERT S. FOX, O.D., F.C.O.V.D.

FOX VISION DEVELOPMENT CENTER

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Latham, NY 12110
Telephone: (518) 374-8001

Signature on File Form

Patient's or authorized person's signature:

I, _____ authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to:

Dr. Robert S. Fox, OD
1202 Troy-Schenectady Road
Latham, New York 12110

Signed_____ Date_____

Insured's or authorized person's signature:

I, _____ authorize payment of medical benefits to:

Dr. Robert S. Fox, OD
1202 Troy-Schenectady Road
Latham, New York 12110

Signed_____ Date_____