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!

Your child will soon be coming for a full developmental vision analysis. This includes testing for vision deficits that can affect overall health, development, self-esteem, coordination, school readiness, and learning to read/write. We will be assessing their eye focusing, eye tracking, eye coordination, acuity, eye health and visual processing 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. Depending on the age and developmental level of your child additional testing may be necessary to develop a program of care to help your child. The fee for this testing ranges from $200-$380.00.

Please bring a few of your child's favorite small toys, as they can be helpful during the examination.

We look forward to meeting you.

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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Child's Full Name _____ DOB_____
Address _____
Primary Contact Number: _____
Child's School_____ Grade_____ Teacher_____
School Address _____
Who referred you to our office? _____
Briefly Describe the Reason for Today's Visit: _____
_____

Parent Contact Information:
Parent/Guardian Name _____
Occupation _____ Work Number_____
Email address _____ Cell Number _____
Marital Status _____
Parent/Guardian Name _____
Occupation _____ Work Number_____
Email address _____ Cell Number _____
Marital Status _____

Medical History
Pediatrician's Name: _____ Date of Last Evaluation: _____
For what reason? _____
Results and recommendations: _____
_____
Medications currently using, including vitamins and supplements:_____
_____
For what condition(s)? _____
_____
Immunizations child has received and dates:
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____
Immunization type: _____ Date: _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes, explain: _____

List illnesses, bad falls, high fevers, **ear infections,** etc.:

Age	Severe	Mild	Complications

_____
_____
_____
Is your child generally healthy? Yes ☐ No ☐
If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐
If yes, please list: _____
Has a neurological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____
_____

Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? Results and recommendations: _____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	____	High Blood Pressure	☐	☐	____
"Cross" or "Wall" eye	☐	☐	____	Learning disability	☐	☐	____
Chromosomal imbalance	☐	☐	____	Amblyopia (lazy eye)	☐	☐	____
Glaucoma	☐	☐	____	Multiple Sclerosis	☐	☐	____
Other	☐	☐	____	Epilepsy or seizures	☐	☐	____

If other, please explain: _____

Developmental History
Full-term pregnancy? Yes ☐ No ☐
Did the mother experience any health problems during the pregnancy? Yes ☐ No ☐
If yes, explain: _____
Normal birth? Yes ☐ No ☐
Any complications before, during or immediately following delivery? Yes ☐ No ☐
If yes, explain: _____
general growth or development? Yes ☐ No ☐
If yes, why? _____
Has your child received any special developmental guidance/ assistance? Yes ☐ No ☐
If yes, explain: _____
How many hours daily does your child sleep? _____
Does your child sleep through the night? Yes ☐ No ☐ If yes, starting at what age: _____
If no, explain: _____
What things can your child do very well? _____
What things, if any, are difficult for your child? _____

Nutritional Information
Are there any food allergies/sensitivities? Yes ☐ No ☐
If yes, what: _____
Activity Level: High ☐ Moderate ☐ Low ☐
Are there periods of very high energy Yes ☐ No ☐
Are there periods of very low energy? Yes ☐ No ☐

Visual History
Why do you feel your child needs a visual examination? _____
Has your child's vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____

Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they used? Yes ☐ No ☐ If yes, when? _____
If not used, why not? _____
Was surgery, therapy or other treatment recommend? Yes ☐ No ☐
If yes, what? _____
_____
Members of the family who have had visual attention and the reason:

Name / Relationship	Age	Visual Situation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	_____
Reddened or encrusted eyelids	☐	☐	_____
Frequent sties	☐	☐	_____
Eyes in constant motion	☐	☐	_____
Eyelids droop	☐	☐	_____
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	_____
Is abnormally bothered by bright light	☐	☐	_____
Seems visually unaware	☐	☐	_____
Has watery eyes	☐	☐	_____
Turns head to use one eye only	☐	☐	_____
Tilts head to one side	☐	☐	_____
Moves objects very close to look at them	☐	☐	_____
Squints while looking at objects	☐	☐	_____
Blinks excessively	☐	☐	_____
Has a tendency to rub eyes	☐	☐	_____

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
Covers or closes one eye	☐	☐	_____
Stumbles over objects or is clumsy	☐	☐	_____
Poor motor control	☐	☐	_____
Lacks interest in looking at objects or seeing	☐	☐	_____
Unable to see distant objects	☐	☐	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	_____
Is unable to stack blocks or other objects	☐	☐	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐
If yes, explain: _____
_____

Pre-School

******If your child attends preschool, please fill out the following:

Name of Pre-school: _____ Teacher: _____ Director: _____

Age at time of entrance to pre-school: _____

Does your child like pre-school? Yes ☐ No ☐

Does your child like teacher? Yes ☐ No ☐

Compared to other children his/her age, do his/her general performance and social skills seem to be

above ☐ equal to ☐ or below ☐

Please explain: _____

Which pre-school activities are easy for your child? _____

_____

Which pre- school activities are difficult for your child? _____

_____

Specifically describe any pre-school / day care concerns / difficulties: _____

_____

_____

Does your child seem to be under tension at pre-school/day care? Yes ☐ No ☐

If yes, explain: _____

_____

Current Abilities/Behavior

Where appropriate, list the age at which your child could do the following: (some of these behaviors may not apply due to your child's chronological age).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Become toiled-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes ☐ No ☐ If yes, which? _____

Can your child identify numbers or letters? Yes ☐ No ☐ If yes, which? _____

Does your child like to draw/color? Yes ☐ No ☐

Is your child learning to read? Yes ☐ No ☐

How is your child performing as compared to others his/her age:

Above average ☐ Below average ☐

How well developed is your child's spoken vocabulary? _____

How well does your child understand/respond to spoken language? _____

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervous	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Bad temper	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain): _____

_____

Give a brief description of your child as a person:

_____

_____

_____

_____

_____

_____

Is there any other information that would be helpful/important in our evaluation or treatment of your child? _____

_____

_____

_____

_____

_____

_____

_____

_____

Release of Information and Insurance Filing

It is often beneficial for us to discuss examination results and to exchange information with your child's pediatrician, daycare, pre-school, and/or other professionals involved in his/her care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Fox Vision Development Center when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims.

_____ _____

Parent's or Guardian's Signature Date

I hereby give my permission to the Fox Vision Development Center to treat _____.

(Child's Name)

_____ _____

Parent's or Guardian's Signature Date

This authorization is valid for the duration of treatment 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 of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, 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 examination, so that we will have the maximum opportunity to evaluate your child's visual status.

Please bring, if applicable, diapers, a bottle, and a few of your child's favorite toys.

Please do not bring any other children with you because your undivided attention is necessary during the evaluation.

THANK YOU.

SINCERELY,

Robert S. Fox, O.D.

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

Primitive Reflex Screening Questions

Were there any medical problems during pregnancy such as threatened miscarriage, high blood pressure, or excessive morning sickness?

YES **NO**

Were there any complications during pregnancy or delivery such as prolonged labor or fetal distress?

YES **NO**

Was a Caesarian section performed?

YES **NO**

Was your child more than 2 weeks premature or 2 weeks late?

YES **NO**

Is there any history of learning difficulties in the family?

YES **NO**

Has your child been diagnosed with a learning disability?

YES **NO**

Has your child been diagnosed with ADD/ADHD or Autism Spectrum Disorder?

YES **NO**

Did/does your child suffer from chronic/frequent ear infections?

YES **NO**

Did/does your child have a history of allergies, asthma, or frequent illness?

YES **NO**

Does your child have a chronic digestive disorder?

YES **NO**

Is/was your child a bed wetter past the age of 5 years old?

YES **NO**

Does your child suffer from motion sickness?

YES **NO**

Has your child ever suffered a head injury?

YES **NO**

Has your child experienced severe emotional stress (i.e. parental divorce, death of someone close, abuse)?

YES **NO**

Was there a lack of, or little, creeping or crawling <u>on all fours</u> with your child?

YES **NO**

Was there any troubles with feeding or latching on in the first 3 months?

YES **NO**

Does your child have difficulty distinguishing between right and left?

YES **NO**

Is, or did, your child have difficulty deciding which hand they would use as their dominant hand?

YES **NO**

Does your child have difficulty sitting still and/or paying attention?

YES **NO**

Does your child have difficulty catching a ball or have poor eye-hand coordination?

YES **NO**

Does/did your child have difficulty learning to ride a bicycle, swim, or swing?

YES **NO**

Does your child become easily anxious?

YES **NO**

Patient Name: _____

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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.

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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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Telephone: (518) 374-8001

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: