Primary EyeCare Associates
Connie Holdheide, Office Contact/ Privacy Officer
1086 Fairington Drive, Sidney, OH 45365
937-492-9197
eyedocs@primaryeyecare.org

Notice of Privacy Practices

CONSENT FOR TREATMENT

While at Primary EyeCare, I consent to all eye evaluations, test and treatments determined to be necessary for me by my doctor. I further consent to my doctor's use of other authorized individuals to assist in my treatment.

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I further hereby assume financial responsibility for all charges incurred in consideration of the services rendered, including services that are not covered by Insurance Benefits. I further authorize direct payment to Primary EyeCare for any insurance benefits or Worker's Compensation Benefits otherwise payable to the undersigned for this treatment at a rate not to exceed Primary EyeCare's regular charges. It is agreed that payment to Primary Eyecare, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment.

APPLICABLE TO MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any owner of medical or other information about me to release to the Social Security Administration or its intermediaries of carriers any information needed for this or any related Medicare claim. I further request that payment of authorized benefits to be made on my behalf.

RELEASE OF INFORMATION

I further authorize the release of medical information, needed to process any related claims, to my health/vision insurance, my employer to process safety glasses, or service organization. My signature on this form authorizes the above-mentioned releases and acknowledges the receipt of the HIPPA information. Copies of the Privacy Practices are also available upon request at our reception area.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of **PRIMARY EYECARE ASSOCIATES,** Notice of Privacy Practices.

Date_____ Patient/Guardian Name_____

Signature_____

AUTHORIZATION OF HEALTH INFORMATION TO FAMILY/FRIENDS

May Primary Eyecare Release your medical/vision information to family/friends? ____YES ____NO

Names_____

_____

May Primary Eyecare leave a message on your home/cell phone regarding your appointment, test results, or upcoming appointments? ___YES ___NO

Rvsd:10/01/2016 ch