Receipt of Notice of Privacy Policies & Consent Form

2321 W. March Lane #A, Stockton, CA 95207 Office: 209-957-8000 Fax: 209-957-8077

158 N. Maple Avenue Manteca, CA 95336 Office : 209-239-3504 Fax: 209-239-0741

Patient Name: ______________________________________

Patient Phone #: _____________________________________

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriated for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtain payment; (2) our submission of claims to third- party payers or insures for claims review, determination of benefits and payments; (3) our submission of your health information to auditors hired by a third- party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you understand our *Notice of Privacy Practices.* You have the right to ask us to restrict the uses or disclosures made for perform healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from *Midtown Optometry.*

____ _________________________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_______________________________________ ____

Relationship to the Patient Print Name

Source of Authority: ____