Consent For Use Or Disclosures Of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right To Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right To Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Appointment Reminders and Health Care Information Authorization

Dr. Fry and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or at work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you by phone, e-mail, mail, or fax with these reminders and information.

Patient Name (Printed)	Date
Patient Signature	Authorized Provider Representative
Personal Representative (Printed)	Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient

PREMIER EYECARE

"Committed To Your Family's Vision Health"

Patient Name: _____ Person responsible for today's payment _____

Today's payment will be: _____

□ Cash □ Check □ Credit Card

I. Third Party Benefit Plans:

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Premier Eyecare to file complaints in my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster, or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Premier Eyecare directly. If this is not permitted by my policy, then send the check made out to me at the following address:

Premier Eyecare
11121 Kingston Pike, Ste. A
Knoxville, TN 37922

Patient Initials: _____

II. Consent for Treatment

By signing this form, I Consent to treatment for myself and/or on behalf of the Minor for which this Medical History information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further, attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

Patient Initials: _____

THE FINANCIAL POLICY OF PREMIER EYECARE

1. All fees are due the day services are rendered or materials are ordered.
2. We accept the following forms of payment: cash, check, Visa, Mastercard, and Discover.
3. The patient who seeks care is responsible for the payment of all fees.
4. The person who brings a child into the office is responsible for all fees.
5. When we are not a provider for a third party, the patient who seeks care is responsible for the payment of all fees. We will provide a feeslip to submit to your third party for reimbursement directly to you.
6. When we are a provider for a third party, any deductibles, co-payments or patient responsibility fees are due when services are rendered or materials are ordered.
7. Interest will be charged in cases where outstanding fees occur.

Patient/Parent or Guardian Today's Date