EYE ASSOCIATES NORTHWEST

Patient Acknowledgment of Receipt of Privacy Practices Notice

I,_____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights in regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Comprehensive EyeCare Partners
50 S. Stephanie Street, Suite 101
Henderson, NV 89012

ATTN: Compliance Officer
Telephone: 702-463-7653

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature_____ Date_____/_____/_____

For Office Use Only:

We made a good faith effort to obtain an acknowledgment of_____receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons:

- ☐ Patient refused to sign (date of refusal)_____/____/_____
- ☐ Communication barriers prevented obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other_____.

Attempt was made by: _____ Date_____/_____/_____

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NORTHWEST

Consent for Medical Treatment

I hereby consent to all medical treatment or services performed by physicians and staff of Eye Associates Northwest. This includes pupillary dilation and refraction, or any services deemed medically necessary by my provider. I understand that my authorized representative or I have the right to accept or refuse medical care at any time.

Authorization to Obtain Medication List Electronically

I give permission to Eye Associates Northwest to obtain a list of my medications using Surescripts, Health Information Network.

Authorization to Verbally Discuss Protected Health Information

I hereby authorize medical providers and personnel of Eye Associates Northwest to discuss my protected health information including appointment, billing and treatment information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

Missed Appointment & Cancellations

Appointments not kept or cancelled within 24 hours' notice prior to the scheduled appointment time may be charged a $75.00 cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

Acknowledgement of Financial Responsibility

I acknowledge my financial responsibility to pay for all services received from Eye Associates Northwest physicians and staff regardless of insurance coverage, eligibility or referral status.

I understand Eye Associates Northwest will bill my insurance, once as a courtesy based on the information I provide. Any unpaid charges are my responsibility; this includes charges deemed non-covered and charges not paid by my insurance carrier. I understand that follow up on unpaid claims may also become my responsibility.

I authorize release of any medical information necessary to process my insurance claim and also assign to Eye Associates Northwest all payments from Medicare and/or other insurance providers for services rendered.

I give my consent to Eye Associates Northwest and to any of its agents acting on its behalf to communicate with me regarding my accounts through various means such as 1) any cell, landline, or text number that I provide 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I acknowledge that failure to provide prior authorization and/or written referral, if required by insurance, will result in all charges becoming my responsibility.

If the patient is a minor, I consent for medical treatment and confirm that I am financially responsible for services provided to the patient.

My signature indicates I have read and agree to the contents above.

Print Patient Name: _____ Relationship (if not patient): _____

Patient Signature (or Parent/Guardian): _____ Date of consent: _____