EYE CARE & SURGICAL CENTER OF LAUREL

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. The Eye Care & Surgical Center of Laurel will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge and agree that Eye Care & Surgical Center of Laurel may use or disclose my medical information for the purpose of my treatment, obtaining payment for services rendered and healthcare operations. I am aware that the Eye Care & Surgical Center of Laurel may disclose my medical information to a Business Associate for the same reasons, and the Business Associate will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosures, under HIPAA.

Acknowledged and agreed to by:

PATIENT: ____________________________or Representative __________________________

ADDRESS: ____ZIP________________

SOCIAL SECURIY NUMBER:____

HOME PHONE: __________________________ WORK: ______________________________

CELL PHONE:_____________________________

The Federal Government now restricts the office of the Eye Care & Surgical Center of Laurel from discussing your health information and condition with other family members or persons…
unless you specifically give your written permission.
By my signature below, I grant the Eye Care & Surgical Center of Laurel permission to discuss my protected medical information with the following individuals.

______________________________________ _____________________________________

SIGNATURE OF PATIENT: ____

DATE: ______________________ DATE OF BIRTH_______________________

POLICY OF PAYMENT

Payment is required at the time service is rendered. We accept cash, check, Visa, MasterCard, Discover, and American Express. In the event that we file your claim(s) to your insurance company, please realize that the charges are your responsibility. If your insurance company does not cover routine eye exams and any other services performed (example: nerve fiber analysis) you will be responsible for payment in full for these services. The total bill incurred will also be your responsibility if a referral is required/and or authorization and one or both is not presented at the time services are rendered**. Missed appointment fee $25.00 if 24 hour notice is not given prior to your appointment.**

Signed _____________________________________ Date: __________________________

NAME OF YOUR MEDICAL DOCTOR _______________________________________