Parker Eye Center 5127 S. Orange Ave STE 100, Orlando, FL 32809 Phone (407)841-1491

Consent For Medical Treatment And Release Of Information

PATIENT'S NAME:_____**SEX(circle one):** Male Female

PATIENT'S DATE OF BIRTH:_____/_____/_____ **SOCIAL SECURITY #:**_____-_____-_____

***IF CHILD*, PARENT'S NAME:**_____

HOME ADDRESS:_____**CITY/STATE/ZIP CODE:**_____

PHONE: (_____**)** _____-_____ **EMAIL ADDRESS:**_____**@**_____**.com**

MEDICAL INSURANCE NAME:_____ **PRIMARY SUBSCRIBER:**_____

SECONDARY MEDICAL INSURANCE NAME:_____**PRIMARY SUBSCRIBER:**_____

VISION INSURANCE PROVIDER:_____**PRIMARY SUBSCRIBER SS#**_____-_____-_____

Consent for Health Care Services: I authorize consent for medical treatment at Parker Eye Center.
Authorization for Release of Information: Parker Eye Center may release information from my medical records to any health care provider involved in my care and treatment. Parker Eye Center may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Parker Eye Center is no longer responsible for the confidentiality of any information known or possessed by the payer.
Financial Agreement: I understand that there is **no guarantee of payment from any insurance company** or other payer. I agree to pay all charges for the services provided by Parker Eye Center which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Parker Eye Center. **I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.**
Pre-authorization Requirements: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Parker Eye Center charges.
Assignment for Direct Payment: I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Parker Eye Center.
Charge for No Show/Cancellation without 24 hour notice: I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible and have to pay for this charge prior to any further scheduling of appointments. Your insurance company will not be billed for that day.
I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I have received a copy of Parker Eye Center HIPAA Policy. (if I requested)

_____ _____
Signature of Patient or Parent (if minor) Date

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Notice of Privacy Practices HIPPA

This notice describes how your health information may be used and disclosed and how you can access this information *Please review carefully*.

At Parker Eye Center, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.
Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. To make changes, give us your request in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S. W., Room 509F, and Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Lindsey Gasper at (407) 841-1491. This notice goes into effect as of August 1, 2007.

-THIS PAGE IS FOR YOU TO KEEP-

Parker Eye Center
5127 S. Orange Ave STE 100
Orlando, FL 32809
Phone: (407)841-1491
Fax:(407)841-1493

Acknowledgment Of Privacy Practices

I,_____acknowledge that I have received a copy of the Notice of Privacy Practices from Parker Eye Center.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative & Relationship Date

(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

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Specialty Testing

One or more of the following tests may be required during your visit today:

Refraction – This is the portion of the exam where your eye glass prescription is determined. Refractions are not covered by medical insurance so this **$40.00** fee is the patient's responsibility and will be collected at check-in with co-pay the day the service is rendered.

Do you want new glasses?

Do you wear contact lenses?

Have you noticed a change in your vision?

Do you feel your vision is blurry?

IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS SIGN YES BELOW AND $40 WILL BE COLLECTED

X_____ **YES,** I WANT A NEW GLASSES PRESCRIPTION
Sign if you decide YES TODAY.

X_____ **NO,** I DO NOT WANT A REFRACTION DONE
Sign if you decide against procedure TODAY.

Contact Lens Fitting - An exam to fit or prescribe contact lenses, as well as the cost of the lenses will be completed today, at your request. You must have a refraction completed in order to get a prescription for contact lenses. The cost for the fitting and the lenses does vary based on your own prescription needs, and ***is not covered by any medical insurance company.***

For RGP current wearers:

New lens and/or prescription refit cost: $150