DR. SMITH'S EYE CARE

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

12656 JEFFERSON HWY.
BATON ROUGE, LA 70816
PHONE: (225) 751-4100
FAX: (225) 751-4103

DR. SMITH'S EYE CARE

Signature on File Form

• *RESPONSIBILITY STATEMENT* •

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

• *FINANCIAL RESPONSIBILITY* •

By signing this statement you agree to be financially responsible for all charges.

• *AUTHORIZATION TO RELEASE MEDICAL INFORMATION* •

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____ Date_____

Witness _____ Date_____

12656 JEFFERSON HWY.
BATON ROUGE, LA 70816
PHONE: (225) 751-4100
FAX: (225) 751-4103

DR. SMITH'S EYE CARE

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage (VSP, Spectera, EyeMed, Davis etc) is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses. It does allow for screenings of conditions, but once they are determined, then medical insurance is filed on those services. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the visit with your major medical carrier (BCBS, Aetna, UHC, Cigna, etc) and the co-pays for that insurance will apply. Insurance carriers set these rules and our office is required to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you.

1. If you have ANY problems or complaints that MAY be attributable to a medical condition which requires a more in-depth investigation and additional medical decision-making to rule out any underlying eye disease, we will accordingly bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- New or sudden blurry vision
- Flashes or floaters
- Dry or itchy eyes
- Eyestrain or double vision
- Eye pain or redness
- Headaches
- Loss of vision

2. There are a variety of systemic conditions that can profoundly and permanently affect a patient's vision that require a more in-depth investigation, which may include additional testing, follow up visits, and reports to your primary care physician. This type of examination is NOT covered under "vision" plans, and we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Diabetes
- Hypertension
- Thyroid disease
- Lupus or autoimmune disease
- Diseases resulting in use of high risk medications like Plaquenil

3. If you have previously been diagnosed by another eye doctor for any eye issues that require medical decision-making, treatment or management, we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Cataracts
- Amblyopic/lazy eye
- Glaucoma/previous diagnosis of high eye pressure
- Macular or retinal disease
- History of eye surgery

We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your insurance we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above & authorize Dr. Smith & Associates to file my insurance by the above guidelines.

Signature: _____ Date: _____

12656 JEFFERSON HWY.
BATON ROUGE, LA 70816
PHONE: (225) 751-4100
FAX: (225) 751-4103

DR. SMITH'S EYE CARE

PHOTO RELEASE FORM

I hereby grant permission to *Dr. Smith's Eye Care and Optical* to use photographs and/or video of me and/or my minor children taken at *Dr. Smith's Eye Care* in publications, advertising, news releases, social media, web content, and in other communications related to the mission of *Dr. Smith's Eye Care and Optical.*

_____

(Signature of Adult, or Guardian of Children under age 18)

Name _____

Address _____

_____

Primary Phone_____

Email Address (optional) _____

Thank you!

12656 JEFFERSON HWY.
BATON ROUGE, LA 70816
PHONE: (225) 751-4100
FAX: (225) 751-4103