

ARCHIBALD R. MORRIS, OD

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PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up(s) among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions; but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Medicare and other medical insurances may reimburse for Optometric eye examinations under certain circumstances. Some insurance do not cover the "refraction" (\$25.00) part of the eye examination, which determines the prescription for eyeglasses. However, most insurance cover the major costs for your eye health examination if there is a medical diagnosis. The patient is responsible for any co-payments and/or deductibles. The law requires us to keep your signature on file in order to process all necessary forms in and on your behalf.

Patient signature: _____ **Date:** _____