Advanced Eyecare
Blue Springs Optical
For a Lifetime of Healthy Vision

➢ _____
Patient Name (please print)

➢ _____
Personal Representative Name & Relationship to patient (please print)

Acknowledgement of Notice of Privacy Practices

The law requires that Advanced Eyecare, PC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that **(choose one)**:

- ☐ I have read or had explained to me Advanced Eyecare, PC's notice of privacy practice and agree to continue my care with Advanced Eyecare, PC under said terms.
- ☐ I was given the opportunity to read Advanced Eyecare, PC's notice of privacy practice and declined but wish to continue my care with Advanced Eyecare, PC under the terms of Advanced Eyecare, PC's privacy policies.
- ☐ I have read or had explained to me Advanced Eyecare, PC's notice of privacy practice and do not wish to continue my care with Advanced Eyecare, PC under said of terms.
- ☐ The notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described below:

I have read and understand this form. I am signing it voluntarily

➢ _____ _____
Patient/Personal Representative Signature Date

Authorization for Medical Care/Assignment of Insurance Benefits/Release of Information

Authorization for today's service and any future services.

1. **Authorization for medical care**: I do herby consent to, and authorized, all medical and surgical treatment or other medical procedures that mat be performed or prescribed nu my optometrist or any other person whom he/she may designate for me or for the minor person listed below for whom I am legally responsible. I understand that no promise, guarantee or warranty has been made regarding the results of any medical treatment or procedure.
2. **Authorization to pay benefits to medical provider**: I hereby request payment of authorized insurance benefits, including Medicare benefits, be made on my behalf to Advanced Eyecare, P.C. for all services provided by that provider. I certify that the information given by me in applying for insurance benefits is true and correct.
3. **Authorization to release information**: I hereby authorize Advanced Eyecare, P.C. to release any information acquired in the course of my examination or treatment that is necessary to process health insurance claims, including Medicare claims, for payment. I authorize that release of all or any portion of the medical record to any health care practitioner or facility that may be designated by my doctor for the purpose of providing continuing and future care and treatment.

I understand that applying for insurance benefits is no guarantee of payment and I agree to pay for any services or materials not covered or denied by my insurance company.

➢ _____ _____
Patient/Personal Representative Signature Date

Additional Access to Patient Health Information

It is Advanced Eyecare, P.C's policy for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Advanced Eyecare, P.C. staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent.

If you wish for other individuals to have accesses to your vison records, health information, or to bring your child (under the age of 18) to an appointment, please provide us with their information below:

Name (please print)	*Relationship*	*Date of Birth*
_____	_____	_____
_____	_____	_____

I authorize Advanced Eyecare, P.C. to discuss my vison and health information with the individuals listed.

➢ _____ _____
Patient/Personal Representative Signature Date