

Eyetopia Optometry

2366 El Camino Real Suite 5

Santa Clara, CA 95050

Phone: (408) 246 - 5858 Fax: (408) 246 - 5717

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Eyetopia Optometry** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS -1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature

Date

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Eyetopia Optometry
2366 El Camino Real Suite 5, Santa Clara, CA 95050
Phone: (408) 246 - 5858 Fax: (408) 246 - 5717

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given (available at www.eyetopiaoptometry.com) describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices changes. You can get an updated copy here at the office. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations.

You also signify that you have received a copy of our *Notice of Privacy Practices*. You have the right to ask us to restrict the uses and disclosures made for the purposes of treatment, payment or healthcare operations, but as described on our *Notice of Privacy Practices*, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Eyetopia Optometry.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to patient Print Name

Source of Authority: _____