Advanced Eye Care (DBA)

Bowling Green
1310 Business Hwy 61
Bowling Green, MO 63334
Phone: 573-324-3131
Fax: 573-324-6817

Troy
43 Ellis Ave.
Troy, MO 63379
Phone: 636-528-4144
Fax: 636-528-8317

Winfield
102 Eagle Bluff Hieghts
Winfield, MO 63389
Phone: 636-668-6171
Fax: 636-668-6355

OFFICE CONTACT PERSON: CAROL HUDSON

CONSENT TO USE OR DISCLOSURE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Patient's Name _____

Patient's Account Number _____

Patient's Address _____

Patient's Phone Number _____

In the course of providing service to you, we create, receive, and store health information that identified 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.

We have comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes services 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 submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insures, among other aspects of payment described in our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get your 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 health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or perform health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

Should your account ever become delinquent the undersigned agrees to pay all creditors, collection agencies and attorney fees. If sued, fees may be filed in the county where services were rendered. You agree that our office or any of our business associates may contact you by house phone, cell phone or email concerning your account.

You have the right to ask us to restrict the uses or disclosures made for the purpose of treatment, payment or health care operations, but as described in our Notice of Privacy Practice, 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 restrictions.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Dated **Patient**

If you are signing as a personal representative of hte patient, describe your relationship to the patient and the source of you authority to sign this form.

_____ _____

Relationship to Patient **Print Name**

_____

Source of Authority