Notice of Privacy Practices

Sergeant Bluff EyeCare Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review out Notice before signing this Consent. The terms of our Notice may change, and if we change our notice, you may obtain a revised copy by contacting out office. Sergeant Bluff EyeCare provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Sergeant Bluff EyeCare has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Sergeant Bluff EyeCare reserves the right to change the Notice of Privacy Practices.
- You have the right to request how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.
- The patient may revoke this Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.
- Sergeant Bluff EyeCare may condition treatment upon the execution of this Consent.
- By signing this form, you consent to out use and disclosure of protected health information about you for treatment, payment, or health care operations.

Date:_____ Signature of Patient or Responsible Party:_____

Signature on File for Insurance

I hereby authorize Sergeant Bluff EyeCare to submit my insurance claims and that payment of authorized insurance benefits (including Medicare benefits) for any services furnished to me, be made on my behalf to Sergeant Bluff EyeCare. I understand that I am responsible for any amount not covered by my insurance(s).

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

Date:_____ Signature of Patient or Responsible Party:_____