Receipt of Notice of Privacy Policies and Consent Form

Westbrook Vision Center PLC.
8877 W Union Hills Dr Ste D460 Peoria AZ 85382

This form must be signed by the patient or guardian of the patient for our office to provide services to the patient.
Federal Law requires us to use this form and accept and enforce these policies.
This form is mandated by the Health Insurance Portability and Accountability Act (HIPAA) Federal Law [45 CFR § 164.506]

Summary: HIPAA DOCUMENT MEANING & Purpose: The purpose of this document is to protect patient rights to privacy. This document states the office of Drs. Deemer, Smith & Associates, P.C. is compliant with the HIPAA rules & regulations and we are to protect your health care information.

You "the patient" **may refuse to sign this document**. Refusal to sign does not give our office permission to submit vision care claims on your behalf or obtain authorization or proof of insurance of your behalf, therefore, you **"the patient", will be required to pay in full at time of service with CASH** (No discounts or insurance plans will be accepted).

→ Patient Name: _____ _____
Print First Name Last Name

This document is now required when you see Healthcare Professionals. In the course of providing services 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 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 you 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) 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* will be updated whenever our privacy practices change. 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 your 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 or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy a 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 Drs. Deemer, Smith, and Associates, P.C.

→ **Signature**_____**Date**_____

If you are under 18 years of age, a guardian, or parent must sign below
Signature _____ Print Name_____
Source of Authority [ ] Guardian [ ] Parent [ ] Other_____ Date____/____/20___