PARKE VISION CARE

Patient Name:____ Date of Birth:______________________

Authorization for Release of Identifying Health Information: ***PLEASE READ AND SIGN BELOW***

I authorize the professional office of my optometrist named above to release health information identifying me as requested by my insurance carrier and/or Worker's Compensation carrier. In the event I pay for services in cash, I may instruct my provider to not share any information about my treatment with my health plan. Additionally, I authorize Parke Vision Care to release information to any physician or hospital I may be referred to by my optometrist. I may request a copy of my medical record in electronic form.

Consent of Treatment: I hereby grant MY authorization and consent for medical treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as the results which may be obtained

Privacy Practices (see additional sheet):

These privacy practices are observed by the doctors and staff at Parke Vision Care. I acknowledge that a copy of my provider's privacy practices was made available to me. I understand that my personal information will not be disclosed for marketing/fundraising purposes without my prior authorization.

Authorization to discuss your care with family or caregivers:

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to have permission to answer questions or discuss your case to anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn by you at any time.

Name:____________________________________ Name:________________________________

Relation:__________________________________ Relation:______________________________

Phone:____________________________________ Phone:________________________________

☐ **I prefer to not have any information released to family/caregivers**

Parke Vision Care is committed to caring for our patient's complete ocular heath. Our patients will receive a complete eye health examination. Our doctors are trained to diagnose and treat most ocular diseases.

As courtesy to our patients we are happy to file with your insurance company. **NOTE:** the patient is responsible for any co-pays and/or deductibles which your insurance states. ***You may be required to pay this upon check in.***

ROUTINE VISION EXAMS will be filed with a patient's Vision Plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia, hyperopia, astigmatism, and presbyopia.

If a **MEDICAL DIAGNOSIS** (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, etc.) is determined by the doctor the patient's exam is no longer routine, but medical. This means we will bill your Health (Medical) Insurance. We request a copy of your medical card in your chart for these reasons

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I, __________________________, been presented a copy of the HIPAA privacy act. I have read it and understand the content. I know that at any time I can request my own personal copy of the form.

I, __________________________, have read and understand all of the above information.

______________________________ ______________________________ _________________

Signature of patient or Guarantor | Relationship if not patient | Date