HIPAA CONSENT FORM

Lascassas Eye Care, PLLC provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Lascassas Eye Care, PLLC and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Lascassas Eye Care, PLLC or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment & referral
- To obtain payment & file insurance
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and insure all our patients receive quality care
- For research and education
- To prevent serious threats to health safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Lascassas Eye Care, PLLC may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Lascassas Eye Care, PLLC. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon me, which may be advised or necessary.

The information and Notice of Privacy Practices is made available on request.

Signature: _____ Social Security: _____

Patient Name: _____ Date: _____

Relationship (if other than patient): _____

Witness (practice representative): _____

INSURANCE CONSENT AND RELEASE

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the following insurance companies and assign directly to Lascassas Eye Care, PLLC all insurance benefits, if any, otherwise payable to me for services and/or materials rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the optometrists and their respective assistants to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance #1 _____
Insurance #2 _____
Insurance #3 _____

Member Name: _____ Date: _____
Member Signature: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Lascassas Eye Care, PLLC for services furnished me by Lascassas Eye Care, PLLC. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.** In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

Beneficiary Name: _____ Date: _____
Beneficiary Signature:_____