MINADEO EYE CENTER

PATIENT CONSENT FORM
(please fill in all information)

Our 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 our Notice before signing this Consent. White binders containing our Notice of Privacy Practices are located in the waiting areas and at the check-in counter for your review. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict 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 that agreement.

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. The Practice 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.
- ☐ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ☐ The Practice reserves the right to change the Notice of Privacy Policies.
- ☐ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- ☐ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ☐ The Practice may condition treatment upon the execution of this Consent.
- ☐ I grant access to Minadeo Eye Center to electronically access my medication history.

This Consent was signed by _____
Printed Name - Patient or Representative

Relationship to Patient (if other than patient) _____

Date _____

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

I authorize Minadeo Eye Center to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Dr. Minadeo, and his staff members my permission to discuss freely my condition, treatment or diagnosis with that person. **YES / NO**

HOME PHONE _____ May we leave a message? **YES / NO**

WORK PHONE _____ May we leave a message? **YES / NO**

CELL PHONE _____ May we leave a message? **YES / NO**

EMAIL ADDRESS _____ May we leave a message? **YES / NO**

MAY WE CALL YOUR NAME OUT LOUD IN OUR LOBBY? **YES / NO**

TO WHOM MAY WE DISCUSS FINANCIAL ISSUES RELATING TO TREATMENT & DIAGNOSIS? _____

HOME PHONE: _____ **SIGNATURE:** _____
(PATIENT OR REPRESENTATIVE)