PRAIRIE
Eye Center, LTD

Notice of Privacy Practices & Patient Consent for Use & Disclosure of Protected Health Information

- I have certain Patient Rights regarding my protected health information under the Health Insurance and Accountability Act of 1996 (HIPAA).

- Prairie Eye Center, Ltd. (the practice) with locations in Springfield, Decatur, Jacksonville, Lincoln, and Hillsboro, Illinois may use or disclose my protected health information for treatment, payment, or health care operations – which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

- Prairie Eye Center, Ltd. has a detailed "Notice of Privacy Practices" document. That document has a more complete description of your rights to privacy and how the practice may use and disclose protected health information.

- I have the right to read the full "Notice of Privacy Practices" before signing this agreement. The most current "Notice of Privacy Practices" is available at any practice location and on the practice website as well.

My electronic consent below indicates that I have been given the chance to review a copy or image of the full Notice of Privacy Practices. My signature means that I agree to allow Prairie Eye Center, Ltd. to use and disclose my protected health information to carry out treatment, payments, payment and health care operations, including release of medical information to my insurance / Medicare carrier to determine benefits payable for related services. I understand that I am financially responsible to the practice for any charges covered by this authorization. **Some routine eye-care costs (refractions & some diagnostics) are generally not covered by insurance or Medicare.** I understand that these costs are my responsibility. In the event collection efforts become necessary, I agree to pay all reasonable collections costs up to 40% of the amount owed, plus reasonable attorney fees and court costs. I have the right to revoke this consent in writing at any time, except to the extent that Prairie Eye Center, Ltd. has acted relying on this consent.

Legal name required for insurance purposes (Please print)

Name: (first / middle / last)

_____

Date of Birth: _____ Email: _____

Cell # _____

Permission granted for the practice to do the following:

- Leave a message on your answering machine and/or voicemail. Yes No
- Send a text message to your cell phone. Yes No
- Send an email. Yes No
- Discuss your health care issues with your spouse or other designated person. Yes No

Patient or representative signature: _____