



Your complimentary use period has ended. Thank you for using PDF Complete.

Click Here to upgrade to Unlimited Pages and Expanded Features



Insurance assignment: I authorize release of Private Health Information for the purpose of obtaining payment from my insurance plan for all services rendered by Barrow Eye Center. I authorize payment directly to my provider, and I understand that I am responsible for my bill, if my insurance does not pay in full, or does not cover rendered services.

I have read and understand the above statements.

Signature : _____ Date: _____

HIPAA Privacy Notice to Our Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so they may understand and comply with government rules and regulations regarding HIPAA, with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the rules mandated by HIPAA. Our practice is determined not to contribute in any way to the improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us to prevent an inappropriate use of PHI. However, it is necessary to routinely use PHI in the normal course of conducting a medical practice. Some examples of how we use your PHI include, but are not limited to the following: preparing and sending insurance claims and patient bills, referrals to other providers, requesting records from other providers, faxing or calling in prescriptions, sending appointment reminders or calling patients about appointments. We may also use PHI in collecting unpaid balances through another agency. However, any outside entity that we use also has a "Privacy Rule" plan in place, and we have contracts with them to assure your PHI is secure. We will not disclose your PHI in any way, other than in the normal course of providing your eye care without your written permission. If we request your permission for disclosure, you are not required to grant it. We will only discuss your treatment with you or your family and friends that assist you with your eye health care. If you prefer that we not leave messages for you on an answering machine or with a family member, please tell us, and we will contact you directly. By signing the notice below, you acknowledge that we have provided you with information regarding our protection of your Personal Health Information.

I acknowledge that I was offered the opportunity to receive a copy of Barrow Eye Center's Notice of Privacy Practices. I also acknowledge that I agree to allow Barrow Eye Center to use my PHI in any way that is necessary for the treatment, consultation, payment from my insurance provider, or in preparing statements or reminders to be sent to me.

Signature : _____ Date: _____