LOOKING GLASS OPTOMETRY

Valley Center Medical Building
401 Gregory Lane, Suite 110
Pleasant Hill, CA 94523

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I acknowledge I have received a copy of the "Notice of Private Practices" of this office.
(Circle) YES NO Yes, on a previous visit

Patient Name: _____
Signature: _____
Relationship to Patient: _____
Date: _____

I do hereby assign to Looking Glass Optometry all vision and medical benefits to which I am entitled for services rendered by this office, and I understand that I am responsible for all charges whether or not paid for by the insurance company. I also understand that if the insurance company does not pay benefits within 90 days of the professional services, I may be billed for the balance of fees.

I authorize Looking Glass Optometry to release all information necessary to secure payment of my benefits.

I understand checks may be deposited through electronic transfer of funds and that I will be responsible for a $25.00 fee for any return checks as well as a 10% APR interest on any unpaid balance.

I understand that my order is specially designed and custom made for my prescription, therefore all sales are final.

SIGN _____ DATE _____