Medical Vision Center
Donald A. Carroll, O.D.
240 W. Main St.
Morton, WA 98356
(360) 496-5140 fax (360) 496-6039

CONSENT TO USE OR DISCLOSE Health INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient name_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and **disclose this** health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that **describes** these uses and **disclosures** in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as maybe necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment: our submission of claims to third-party payers or insurers for claims review. Determination of benefits and payment: our submission of *your* health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website at wwwmedicalvisioncenter.com. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our service & and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment payment of health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Date_____ **Patient Signature/Gaurdian** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name _____

Source of Authority: Parent___ Power of Attorney___ Legal Guardian___ Grandparent___ Other_____

I authorize my personal health information to be shared with:
Husband____ Wife____ Child___ (Name) _____ Caregiver___ (Name) _____
Other_____

Initial_____

Medical Vision Center may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may leave a detailed message on your phone/message phone/cell phone or with the individual who answers your phone if you not at home, or at your place of employment.

I authorize Medical Vision Center to leave a detailed message on my:

Home phone:	Yes/ No
Work phone:	Yes/ No
Message Phone:	Yes/ No

Initial_____

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED ON A YEARLY BASIS.

The: Private Insurances (Non-Medicare Patient)

I hereby assign to Medical Vision Center/Donald A. Carroll, O.D. any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Medical Vision Center/Donald A. Carroll, O.D. for services provided to the Patient by Medical Vision Center/Donald A. Carroll, O.D.. I certify that the information given to me to Medical Vision Center/Donald A. Carroll, O.D. in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to Medical Vision Center/Donald A. Carroll, O.D. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Medical Vision Center/Donald A. Carroll, O.D. in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature:_____Date_____