

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Financial Responsibility

I hereby authorize CDR Eye Associates to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my insurance carrier be made directly to CDR Eye Associates. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurance carrier.

I certify that the information I have reported with regard to my coverage is correct. I further authorize CDR Eye Associates to release to my insurance company and its agents any information related to this or any related claim.

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Member's Signature and Date

# ALL ABOUT EYES

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Street \_\_\_\_\_ Apt. # \_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex M \_\_\_\_ F \_\_\_\_ Parent/Guardian \_\_\_\_\_  
 Email \_\_\_\_\_ Occupation/School \_\_\_\_\_  
 Hobbies/Interests: \_\_\_\_\_

Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_  
 Insurance ID \_\_\_\_\_ Employer \_\_\_\_\_  
 Primary DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Reason for visit? \_\_\_\_\_ Who referred you? \_\_\_\_\_  
 Date of last eye exam? \_\_\_\_\_ By whom? \_\_\_\_\_

Have you ever been treated for or told you have the following?

Medical

Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Respiratory Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sinus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis A B C	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pregnant now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other? \_\_\_\_\_  
 \_\_\_\_\_

Ocular

Blurred Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Double Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Flashes of light	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Floaters	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye Turn or Lazy Eye	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dry Eye	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have glasses?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have contacts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Family History

Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blindness	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current Medications

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |