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:

____

____

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.

____

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 ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Thyroid	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Respiratory Problems	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Sinus	Yes ☐	No ☐
Allergies	Yes ☐	No ☐
HIV	Yes ☐	No ☐
Hepatitis A B C	Yes ☐	No ☐
Pregnant now?	Yes ☐	No ☐
Do you smoke?	Yes ☐	No ☐

Other? ______________ ______________

______________ ______________

Ocular		
Blurred Vision	Yes ☐	No ☐
Double Vision	Yes ☐	No ☐
Cataracts	Yes ☐	No ☐
Flashes of light	Yes ☐	No ☐
Floaters	Yes ☐	No ☐
Eye Injury	Yes ☐	No ☐
Eye Surgery	Yes ☐	No ☐
Eye Turn or Lazy Eye	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Macular Degeneration	Yes ☐	No ☐
Dry Eye	Yes ☐	No ☐
Have glasses?	Yes ☐	No ☐
Have contacts?	Yes ☐	No ☐

Family History		
Glaucoma	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Macular Degeneration	Yes ☐	No ☐
Blindness	Yes ☐	No ☐

Current Medications

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________