NOTICE OF PRIVACY PRACTICES PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may retain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance of your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution on this Consent.

______________________________ Signature – Patient or Representative

______________________________ If Representative – note relationship to patient

______________________________ Witness: Printed Name – Practice Representative

______________________________ Date

FINANCIAL POLICY ACKNOWLEDGEMENT FORM

The Shenandoah Eye Clinic financial policy requires that you read, understand, and sign acknowledgement prior to treatment. A full version of the Shenandoah Eye Center Financial Policy has been provided to you. The following is a statement of our Financial Policy.

- All patients must complete our Information and Insurance form before seeing the doctor. We verify your insurance information at each, so please **bring your insurance card(s) with you to every appointment**. In order for us to bill your insurance company we need complete, current, and accurate information, including a copy of your card. It is your responsibility to inform the front desk personnel when the cause for treatment has resulted from an injury that should be billed to workers' compensation.
- In the event your insurance does not pay, Patient will be responsible for services provided.
- If you currently have no insurance, all services provided are to be paid in full at the time of service. All copayments, deductibles, and coinsurance are due at the time of services.
- Payments must be made with cash, personal check, Visa, MC, Disc, AmEx, or Care Credit.

I acknowledge receipt of this Financial Policy and have read or have had it read to me. I understand and agree to the provisions and terms as listed above.

______________________________ Patient Name (PLEASE PRINT)

______________________________ Patient Signature Date

______________________________ Legal Custodian or Representative (PRINT)

______________________________ Legal Custodian or Representative Signature