PATIENT PRIVACY POLICY WAIVER

Gray Vision Health Center believes that the privacy of your medical records and identifiable information is very important. A statement of our Privacy policy has been posted throughout the office for patient convenience. **PLEASE READ THIS POLICY AS IT HAS BEEN PROVIDED FOR YOUR INFORMATION AND BENEFIT.**

As a part of the privacy policy, it is recommended that patients other than minor children under the age of 7 yrs. old not be accompanied to the examination room. *Dr. Gray and his staff cannot protect the privacy of a patient if a third party has been allowed in the examination room during the examination process.* This includes, but is not limited to mother, father, spouse/partner, sibling, friend, etc.

I, _____(patient), have been informed of the Patient Privacy Policy and have chosen to waive this right regarding the examination process. I have allowed _____, a third party to be present during the examination and understand that results of the examination, medical information and other information will be disclosed during this examination.

I, _____(patient), have been informed of the Patient Privacy Policy and have elected to allow my Personal Health Information to be released to the following third party individual (s) upon formal request in accordance to the policy.

_____ _____

Patient Signature/Date: _____

Witness Signature: _____

ACCEPTANCE OF PRIVACY PRACTICES

In compliance with the Federal regulations of HIPAA's Privacy Rule, I have read and accept the notice that describes how my medical information may be used and disclosed and how I can obtain access to my medical information. I also understand that I will be charged $1.00 for each page copied up to five pages and $0.25 for additional copies with a minimum fee of $5.00 for copies of my medical record.

Patient Signature/Date: _____

NO SERVICES WILL BE RENDERED IF PRIVACY PRACTICES ARE NOT ACCEPTED BY PATIENT/GUARDIAN

DILATION CONSENT:

Dilation of the pupil of the eye allows the doctor to better evaluate The retina (the back layer of the eye) and other interior structures. This aids in the process of detecting the presence of tumors, retinal detachments, cataracts, glaucoma, and other ocular pathologies. It also helps in determination of the origin of flashes of light and the sudden appearance of floaters.

We routinely dilate all patients in this office as a part of a comprehensive eye examination. Occasionally, the doctor will defer the dilation to another office visit. If requested by the patient, the dilation may be postponed; however, there will be an office visit charge for this second appointment.

Having read the above, I hereby CONSENT to have my eyes dilated:

(YES) Patient's Signature: _____

(NO) Patient's Signature: _____

Date: _____

SIGNATURE ON FILE AND CONSENT INFORMATION:

( ) I authorize use of this form on ALL my insurance submissions.

( ) I authorize the release of information to all my INSURANCE COMPANIES.

( ) I authorize my doctor to act as MY agent in helping obtain payment from my Insurance Company.

( ) I authorize PAYMENT DIRECT TO MY DOCTOR.

( ) I permit a copy of this authorization to be used in place of the original.

( ) I understand that I AM RESPONSIBLE for my bill. This includes **charges for co-payments, deductibles, and any services considered "non-covered"** by my insurance company. **PAYMENT IS DUE ON THE DATE OF SERVICE.**

( ) **This office will no longer file insurance for patients if we do not have the necessary information and insurance card copies prior to rendering of services.** If I cannot present or fail to present current insurance card or proof of coverage, I understand that I will be required to pay in full on the day of the visit..

Signature: _____Date: _____
(Patient or Guardian if a minor)

Print Name: _____Medicare/Insurance #: _____

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