THE MEDICAL & SURGICAL EYE CENTER
NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and physician certifications.

I understand a copy of the "Summary Notice of HIPPA Privacy Practices" containing a more complete description of the uses and disclosures of my health information has been made available to me. I understand that the Medical & Surgical Eye Center (hereafter referred to as MSEC), has the right to change its "Notice of HIPPA Privacy Practices" from time to time and that I may contact them to obtain a current copy of the "Notice of HIPPA Privacy Practices".

I understand that I may request in writing that MSEC restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that MSEC is not required to agree to my requested restrictions, but if MSEC does agree then MSEC is bound by such restrictions.

I grant permission to the doctors and staff of the Medical & Surgical Eye Center to discuss my diagnosis and treatment rendered by the Medical & Surgical Eye Center with the following individuals:

Name **Relationship to Patient**

_____

_____

Do you give MSEC permission to leave a recorded message for you? ◯ **Yes** ◯ **No**

Print Patient Name:_____Date:_____

Signature of Patient (or Guardian)_____

Print Name of Guardian (if applicable)_____

_____

All unpaid deductibles and co-payments are due at the time of service, unless arrangements have been made with our office in advance.

INSURANCE RELEASE AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of the Medical & Surgical Eye Center for professional services rendered. I authorize the release of any medical information necessary to process this claim.
I further understand that a $25.00 fee will be charged for returned checks and balances older that 45 days may be subject to additional collection fees and interest charges of 1½% per month.

I have read, or had explained to me, and understand the contents of this authorization.

Signature:_____Date:_____