



New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, **TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Policies** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that TOTAL EYE CARE CENTERS and/or WOODBOURNE OPTIK, INC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that TOTAL EYE CARE CENTERS and/or WOODBOURNE OPTIK, INC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should TOTAL EYE CARE CENTERS and/or WOODBOURNE OPTIK, INC change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree, email) prior to implementation.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations **Page -2-**

I authorize TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to call in prescription renewals, when I so request, and recognize that the office arrangement may allow for other patients to inadvertently overhear my name and the prescription name(s). I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may be unable to telephone prescription orders and refills and will provide me with written prescriptions, or will require the pharmacist to call the practice for refill orders.

I authorize TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to provide prescriptions and prescription refills to other members of my immediate family.

In the event that I need to be admitted to any hospital, I understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC will be required to call ahead and make admission arrangements for me. In this event, I understand that the office arrangement may allow for other patients to inadvertently overhear my name and the admission information. I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may incur delays with my admission information.

I understand that the practice of TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC is to call me to advise me of the results of laboratory tests or for other purposes. I hereby authorize TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to leave telephone messages at my home phone number that may include negative test results and requests for me to call the office to obtain test results or to make office appointments.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

In the case of a minor, Responsible
Party or Legal Guardian

Date

Relationship

-----**FOR OFFICE USE ONLY**-----

Consent received by _____ on _____.

Employee Signature Date

Consent refused by patient, and treatment refused as permitted.

Consent added to the patient's medical record on _____.

Date