Consent for Examination & Notice of Privacy Practices

Notice of Privacy Practices and HIPAA
This section summarizes the Notice of Privacy Practices adopted by Sun Eye Care, P.A. A complete written notice will be given to you upon your request. It can also be found on our website at www.suneyecare.com. The intent of the Notice of Privacy Practices is to inform you of how we use your protected health information.

In general your protected health information is used for purposes of providing treatment, obtaining payment for treatment and conducting health care operations. Your protected health information may be used or disclosed only for those purposes unless you have given authorization or as otherwise permitted under HIPAA or as required by law. Examples of these additional disclosures include reporting potential risks to public health, reporting suspected abuse or neglect, releasing information in conjunction with judicial proceedings or for law enforcement purposes, for research purposes and for specified governmental functions.

You have rights under HIPAA regarding your protected health information which include the right to inspect and copy your protected health information, the right to receive confidential communications from this office, the right to receive an accounting of releases of your protected health information and the right to receive a paper copy of this notice. You also have the right to request amendments to and restrictions on uses and disclosures of your protected health information. However such amendments and restrictions may be denied by this office as allowed or required under HIPAA.

The terms of this notice may be changed from time to time as required by law or as otherwise necessary. Any changes in the provisions of the Notice would be effective for all future protected health information and would be made available to patients via mail or direct in-person contact.

If you feel that your rights have been violated regarding the maintenance or disclosure of your protected health information, you may express your concerns to either or both the privacy officer of this office, Janene Moore, or to the Secretary of Health and Human Services.

_____ (Initials) I acknowledge that I have read and understood the Notice of Privacy Practices.

Consent for Use of Dilating Medication(s)
Dilating eye drops are used to enlarge the pupil to allow examination of the inside of the eye. Although occurring rarely, risks of these medications include allergic reaction, acute glaucoma, and systemic reactions including increased blood pressure, irregular or fast heart beats and dizziness. Additionally, use of dilating drops will cause blurry vision and light sensitivity which can make driving and certain work conditions hazardous after an eye exam for a period of 4 – 6 hours or more

However, if dilating eye drops are not used, the examination is sub-optimal and certain conditions such as macular degeneration, glaucoma and retinal tumors may go undiagnosed.

_____ (Initials) I consent to the use of dilating eye medications.
_____ (Initials) I decline the use of dilating eye medications.

Acknowledgement of Refraction Policy and Consent for Refraction
Medicare policy requires that refraction (the exam to determine glasses prescription) be billed separately from an eye exam. Medicare and most commercial insurance carriers do not pay for refraction. Patients are responsible for payment of a refraction unless they have a vision plan which covers routine eye care services. Payment is due in full at the time refraction services are rendered.

If you decline having a refraction, there is a greater risk that there may be a delay in diagnosis of some eye diseases which may cause long term vision impairment. Further, declining refraction prior to some surgeries may result in non-payment of the surgery by your insurance carrier or Medicare in which case you would be responsible for payment.

Charge for Refraction as of 1/1/06: $29

_____ (Initials) I acknowledge that I have read and understood the refraction policy.

_____ (Initials) I consent to refraction when determined appropriate by my physician.
_____ (Initials) I decline refraction at this time.

Financial Responsibility & Consent for Treatment
It is the policy of Sun Eye Care, P.A. that payment is due at the time services are rendered. As a benefit to you we will bill services directly to your insurance carrier. However, you are ultimately responsible for all charges including, in the event of default, costs of collection and attorneys' fees.

I hereby authorize the assignment of medical and surgical procedures benefits from Medicare, Medicaid, other governmental insurances and/or private insurance to: Sun Eye Care, P.A., Suite 209, El Paso, TX 79902.

I authorize Dr. Michael W. Foote to provide reasonable and appropriate medical and surgical care consistent with the standards of care of the American Academy of Ophthalmology.

_____ _____
(Signature of Patient or legal guardian) (Date)

_____ _____
(Signature of Witness) (Date)

_____ (Initials) I have read and understood this entire document.
_____ (Initials) This document was read to me by: _____.

_____ (Initials) This document was presented to me in my native language.

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