HIPAA Compliance Patient Consent Form

This notice includes a section outlining your rights under the law regarding your protected health information (PHI). By signing below, you acknowledge that you have reviewed this notice prior to providing consent. Please note that the terms of this notice may change; if so, you will be informed at your next visit and asked to update your signature and date. You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment, or healthcare operations. While we are not obligated to accept such restrictions, if we do agree, we will honor them. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your PHI may be used or disclosed for purposes related to treatment, payment, and healthcare operations. By signing this form, you consent to the use and disclosure of your PHI for these purposes, including potential anonymous use in publications. Additionally, you consent to the disclosure of your PHI—including your name, email address, and information related to your care—to Team Vision, a trusted partner that assists River Valley Eye Professionals with administrative services and for the purpose of offering products and services that may be of interest to you. You have the right to revoke this consent at any time by submitting a written, signed request. Please note that revocation is not retroactive and will not affect disclosures made prior to the revocation. This consent will remain in effect until revoked by you (or your guardian/guarantor), or for a period of seven (7) years from the date of your last service at River Valley Eye Professionals.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The patient has the right to request a copy of this authorization through mail or e-mail.
- The patient understands that the company may receive direct or indirect remuneration from another party in connection with the use or disclosure of their PHI for the purpose described above.
- The patient understands that the health information covered by this authorization is protected by privacy laws. The patient also understands that once River Valley Eye Professionals shares information with Team Vision, it may no longer be protected under the federal privacy law known as HIPAA. However, Team Vision cannot share any information with anyone else unless the patient provides additional permission or the law specifically allows or requires it. Some state laws may provide extra protections for the patients information.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any other individuals? (Specify) ☐ YES ☐ NO

If **YES**, please name the members and relationships allowed:

Name_____Relationship: _____

Name_____Relationship: _____

Name_____Relationship: _____

*If you would prefer to be addressed by a name other than your full given name, what would you prefer for our staff members to recognize you by:_____

This consent was signed by (Print): _____

*If Guardian or Guarantor, this consent is signed for (Print): _____

*If Guardian or Guarantor, relationship to patient: _____

Signature: _____ **Date:** _____

Witness: _____ Date: _____

Patient Care & Financial Agreement

At River Valley Eye Professionals, our mission is to provide exceptional eye and health care using high-quality optometric materials and advanced diagnostic instrumentation. Fees for services are based on the time, expertise, and resources required to deliver your recommended and/or requested treatment.
We make every effort to help you maximize your insurance benefits and offer straightforward payment options. However, **you are ultimately responsible for payment in full**, regardless of insurance coverage, benefit limitations, or any financial arrangements made.

By signing/initialing this agreement, you acknowledge and accept responsibility for all charges incurred during your care, and agree to comply with the payment terms outlined by our office.

Please Initial on Each Line Below:

_____ If you have eye care or health benefits, we are happy to submit the claims to your insurance company on your behalf. However, coverage is not guaranteed. Your insurance policy is a contract agreed upon between you and your insurance carrier, and you are ultimately responsible for all treatment costs.

_____ Payment is expected on the day of treatment. If you have an eye care or health benefit, we will collect your total estimated portion of the copay and/or procedure fees. We accept the following forms of payment: cash, check, and credit/debit cards; including those sponsored by HSA and FSA (Visa, MasterCard, American Express, or Discover). All unpaid balances over 30 days may accrue a finance charge of up to 18% per month, and all unpaid balances after 60 days may be eligible for collections reporting.

_____ Rescheduling Appointments: We understand that your time is valuable, and our practitioners and clinical team dedicate significant effort to prepare for your visit. Missed or unattended appointments limit access to care for other patients. If you need to change your scheduled appointment, we require at least **24 hours' advance notice** so we can offer that time to someone else. If proper notice is not provided, you may be asked to pay a reservation fee to book future appointments, and ideal scheduling times may not be available. **In the event of a no-show, a $50 fee will be charged, and a statement will be issued. This fee must be paid before you can reschedule another appointment.**

_____ Acknowledgment of Prescription Receipt In accordance with FTC guidelines, I acknowledge that I will receive a copy of my eye wear and/or contact lens prescription following a refractive exam. This record will be kept for at least 3 years. I understand I may request additional copies in person or electronically. If my prescription is not yet finalized, it will be provided once complete, with the same retrieval options.

_____Minor(s)/Dependent(s) - If you have a dependent who is under 18 years of age OR that is 18 years and older. You understand and accept full responsibility for all charges or payments due on their account. Before any treatment is rendered, you will be explained options in full, and required to physically sign off on treatment. Although, scheduling an appointment for treatment, and/or dropping your child off for care at our practice will be taken as implied consent. No appointments will be made directly with a dependent.

*Guardian or Guarantor ONLY - Name of Responsible Party (Print): _____

I have read, understand, and agree to the above Patient Care & Financial Agreement:

Name of Patient (Print): _____ Date: _____

Signature of Patient or Responsible Party: _____