RECEIPT OF NOTICE OF PRIVACY AND CONSENT FORM
By signing this form you are protecting your personal health information

The Eye Site of Bluffton
104 Buckwalter Parkway, Unit 1C
Bluffton, SC 29910
843-757-9588

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. The Notice of Privacy Practices you have been or can be given to you describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. A framed copy is posted on the wall. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for the purposes of payment includes; (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers claims for review, determination of benefits and payments; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payments described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses and disclosures made for purposes of treatments, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from The Eye Site of Bluffton.

X _____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name