BROST & Associates FAMILY EYE CARE, P.C.

Kyle E. Brost, O.D. ♦ Meredith E. McLeod, O.D.

Receipt of Notice of Privacy Policies & Consent Form

Patient:____ DOB:_______________________

In the course of providing services to you, we create, receive and store health information that identifies you. If is often necessary to use and disclose this health 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 given describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this form. 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 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 for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment 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 or on our website ***www.brostassociates.com***.

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 or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged 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.

Patients in our practice may be contacted via email, cell phone and/or text messaging to remind you of an appointment, to let you know the items you ordered are ready to pick up, and to provide general health reminders/information. If at any time you provide an email, cell phone number or text address at which you may be contacted, you consent to receiving appointment reminders and other healthcare communications/information at that email, cell phone number or text address from this Practice.

___________ ***(Patient initials)*** ***I consent to receive calls and/or text messages from this practice at my cell phone and any number forwarded or transferred to that number, or emails, to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders or healthcare communications/information unless I request a change in writing.***

- ***The cell phone number that I authorize to receive calls and/or text messages for appointment reminders and other healthcare communications/information is:***

  ____ ***Texting?*** ***Yes*** ***No***

- ***The email that I authorize to receive email messages for appointment reminders and other healthcare communications/information is:***

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Many of our patients allow family members such as their spouse, significant other, parents or children to call and request healthcare and/or financial information. Under the requirements for HIPPA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your healthcare and/or financial information released to any family members, you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize *Brost & Associates Family Eye Care, P.C.* to release my healthcare and/or financial information to the following individuals:

1) _______________________________________ Relationship:______________________
2) _______________________________________ Relationship:______________________
3) _______________________________________ Relationship:______________________
4) _______________________________________ Relationship:______________________

I have read the Notice of Privacy Practices of this office and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

____ Date:___________________
(Patient Signature)

If signing as a personal representative of this patient, describe the relationship to the patient:

____ _____________________________________
(Print Name) *(Relationship to Patient)*