Gramercy Park Optical
344 Third Avenue
New York, NY 10010
212) 679-9690

PATIENT CONSENT FORM

I understand I have certain rights to privacy regarding my protected health in information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected healthcare information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this _____ day of _____, 2011

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

INSURANCE AGREEMENT

Dear Patient,

We welcome you to our office and are glad to be able to assist you with all of your vision needs.

Please be advised that we need to be made aware of your VISION insurance plan prior to the time of examination. If you do not have vision coverage, we accept most major medical plans, but they cover the examination only.

In the event that your coverage is denied upon submission, we will bill you for the cost of the examination. If your deductible has not been met you are responsible for the cost of the visit as well.

I am aware of the above information and am responsible for any fees not covered by my insurance carrier.

Signature: _____

Date: _____

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CONSENT FOR DIGITAL RETINAL SCREENING PHOTOS

At Gramercy Park optical, we are committed to providing the best patient care possible. We are now offering high resolution Digital Retinal screening photos. The photos allow us to carefully examine the central retina and can also detect diabetes, hypertension, glaucoma and macular degeneration. These photos act as a historical record for future comparisons and are not covered by any vision insurance.

We strongly recommend these photos. The fee for this test is $30.00.

☐ I elect to have Digital Retinal Screening photos.

☐ I decline Digital Screening photos.

_____
Patient Signature

_____
Date