ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
RESPONSIBILITY FOR PAYMENT and EMAIL CONSENT
Jacobson Eyecare
245 Bloomfield Drive, Suite 108
Lititz, PA 17543

I consent to the use and disclosure of any information concerning my optometric examination as needed to:

- Conduct, plan or direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance or other payers.
- Conduct normal healthcare operations such as recalls and appointment confirmations.

I have read and understand or have been given the opportunity to read your *Notice of Privacy Practices* containing a more complete description of other uses and disclosures of my health information. I understand that your office has the right to change its *Notice of Privacy Practices* from time to time and that I may request a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If your office agrees to third party reimbursement for services rendered, I authorize you to submit a vision and/or health benefit claim on my behalf. I understand that I am responsible for all charges incurred, including any portion not paid by any other payer, subject to the conditions of any contractual agreement between your office and such payer.

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy. We will only use standard email for general correspondence, financial statements, contact lens and eyeglass prescriptions. We do not send medical records or insurance explanation of benefits by standard email.
___ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.
___ I do not authorize the use of standard email to communicate with me.

I acknowledge that I have read and understand or have been given the opportunity to read your Financial Policy and that may request a copy at any time.

In addition to my primary care physician, my insurance company and the responsible party listed on my patient history, I authorize you to release necessary information to (please list other physicians, family members, opticians, etc.):

_____ _____

_____ _____

_____ _____
PRINT Name of patient SIGN Patient DATE

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____
Representative Signature Relationship to Patient