SUMMIT Eye Care P.A.
Advanced Eye Care Solutions

Vic Khemsara, M.D.

PATIENT CONSENT FORM

The Dept. of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as labs that only interact with physicians) and may have to disclose health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse treatment should you choose not to disclose your Personal Health Information (PHI).

If you give consent in this document, at some future time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice. My signature below acknowledges that a copy of Privacy Practices for Summit Eye Care has been made available to me.

PATIENT _____ Date_____

Authorization for Care and/or Treatment: Knowing that I am suffering from a condition requiring health care treatment, I voluntarily consent to such treatment including diagnostic procedures and medical treatment ordered by my physician. I also voluntarily consent to treatment provided by assistants as judged necessary by my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the results of treatments or examinations by my care givers. This form has been explained fully to me and I certify that I understand its contents. Consequently, I hereby release Summit Eye Care, its employees, agents, and representatives from such legal responsibilities regarding my knowledge of and consent to medical treatment and from such other legal responsibilities to the extent permitted by law.

Authorization for Release of Medical Information: The undersigned authorizes Summit Eye Care or its agents to disclose any medical information currently existing or developed during the course of treatment to: 1) the Social Security Administration or its intermediary, which may be needed for or related to a Medicare or Medicaid claim; 2) state or federal agencies that provide benefits and require such information; 3) a referring physician or facility to which the patient may be referred; 4) third party payers or others involved in processing a claim for benefits for services rendered; and 5) federal, state or local agencies as required to comply with laws and regulations.

Financial responsibility and assignment of Insurance Benefits: The undersigned guarantees payment to Summit Eye Care and/or Accent Optical of all charges for services provided to the patient. I authorize direct payment of surgical and medical benefits by insurance be made payable to Summit Eye Care and/or Accent for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by myself in applying for payment under title XVIII and XIX of the Social Security Act is correct. I also certify that the commercial insurance information I have provided is accurate and complete. I understand that ***I am personally responsible for any fees not paid due to incorrect information*** and that any ***"routine"*** exams performed which are not covered by my insurance will be my responsibility as well.

PATIENT_____Date_____

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