HIPAA AUTHORIZATION

I: FOR USE OR DISCLOSURE OF HEALTH INFORMATION Our Notice of Privacy Practices provides information about how Dr. Neill S. Cowles may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. Name of Patient (print):

The purpose of this authorization is: 1: Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2: Obtain payment from 3rd party payers. 3: Conduct normal health care operations.

My Rights I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. I have read, received, and understand the Notice of Privacy Statement.

Eyewear Policy

If you choose to take your prescription to another vendor in order to obtain frames and lenses, we will be unable to correct any mistakes in the prescription without charge. This includes appointment charges and any charges incurred if ordering new lenses from our Lab.

When updating eyewear with patient own frame; I understand that they may break when new lenses are inserted. I released this office and members of the staff from any claims of damage to the frames as they are being used at my request.

On all RX eyewear we will gladly give you a refund, exchange, or RX change (at no charge) within 30 days. After 30 days exchanges and RX change will vary depending on the type of lenses used. There will be no refunds after 30 days.

Insurance Authorization

II. I authorize the release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances or fees for services not covered by the insurance carrier. I accept there may be fees that occur with missed appointments and cancellations without 24 notices.

III: Dilating drops may be instilled in your eyes during your examination. These drops may blur your distance vision and will most likely blur your reading vision for a few hours. You will also be light sensitive.

Privacy and Insurance Authorization

Signature: _____

Printed Name: _____

Date: _____

Our Office utilizes SMS messages to remind patients of upcoming appointments and eyewear orders. By Signing the form, you agree to consent to having us store your information and send SMS messages.

If you wish to opt-out to SMS messaging from our office sign and date

here: _____

If the patient is a minor (under 18) or unable to sign, please complete the following:

❑ Patient is a minor: _____ years of age ❑ Patient is unable to sign because:

_____

Print Name of Representative: _____

Relationship to Patient_____

Signature: _____Date: _____