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Physicians & Surgeons • Ophthalmology

## ACKNOWLEDGMENT AND CONSENT

I understand that Douglas R. Merritt M.D., Mark J. Maffett M.D., Rodney D. Leavitt M.D., Matthew R. Guymon D.O. and James L. Davidian M.D. (referred to below as " This Practice") will use and disclose **health information** regarding my care (or that of a legal minor/guardian).

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**I understand I will be financially responsible for all services rendered, including, but not limited to, exams, special testing and refraction (test for glasses). Insurance will be billed for services covered by your plan. I will be responsible for any balance due after my insurance has been billed. I understand that I will be financially responsible for all services not covered by my insurance.**

I understand that this authorization is valid indefinitely unless revoked by patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_