



before, make sure it looks the same.

hours in advance or at your earliest convenience.

6. Fulfill financial obligations for his/her care in a timely manner (pay your bill).

4. If in doubt, ask a question.

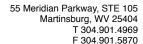
HIPAA INFORMATION AND CONSENT

This Acknowledgement of Notice and Consent authorizes Martinsburg Family Eye Care to use and disclose health information about you for treatment, payment, and health care operations purposes.

1.) Please list the family member or other your diagnosis (including treatment, paym	persons, if any, who may be informed about your general medical condition and nent, and health care operations):
Access granted to:	Relationship:
2.) Please list the family members or signi- IN AN EMERGENCY SITUATION:	ficant others, if any, who may be informed about your medical condition ONLY
Name:	Phone Number:
3.) Please print the telephone number wh or other health care information if other th	ere you want to receive calls about your appointments, lab and imaging results, nan your home phone number.
Contact telephone (with area code)	: <u> </u>
4.) Can confidential messages (i.e. appoint telephone answering machine or voiceman	ntment reminders, lab and imaging results, testing information) be left on your ail? Check here please: []Yes []No
observance of patient rights will contribut doctor and the clinical organization. If you written copy prior to signing this acknowled Furthermore, Martinsburg Family Eye Care	e expects that they will be supported by the clinic on behalf of its patients, as an
structure. We present your responsibilities	elationship between the doctor and the patient is essential for the delivery s as a patient below.
Statement of Patient Responsibilities:	
	t the best healthcare results from a real partnership between patients and their ent involve you actively being involved in your care. This includes:
	curate, and complete information about present complaints, past conditions, ditions, and other matters pertinent to his/her health.
2. Understand and follow the treatment pothe provider when he/she does not under	lan recommended by the provider or ask questions and discuss concerns with rstand or agree with the plan of treatment
3. Pay attention to your medications.	
3.1. Tell your doctors or nurses abo	ut any allergies or serious problems you have with a medicine.
3.2. Be sure you understand what th	ne medicine is for and how you are supposed to take it.
3.3 When you pick up your medicir	ne, check the bottle; be sure it has your name on it. If you've taken the medicine

5. Keep appointments reliably and promptly or notify Martinsburg Family Eye Care when unable to do so, calling 24-36

03/06/2019 revision JDA





7. Be respectful of others while at Martinsburg Family Eye Care. Cell phones must be turned off throughout patient care areas due to HIPAA laws. Cell phone conversations and messaging must be conducted outside of the practice limits.

8. If you have a test; don't assume no news is good news. Ask for the results if you aren't contacted by your doctor or staff.

Notice of Privacy Practices: Martinsburg Family Eye Care has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your Protected Health Information (PHI) and exercise other rights concerning your protected health information. *You may ask to review our current notice prior to signing this acknowledgement and consent.* You may also request a written copy of our notice. By signing this consent:

I consent to treatment necessary for the care of the patient named below.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of all medical records, if necessary.

I authorize Martinsburg Family Eye Care to use photos or information concerning my case in the interest of medical education, and I understand that I will not be identified by name or other protected information.

I acknowledge that I am responsible for payment at the time of each visit for all services rendered by Martinsburg Family Eye Care which are not covered by an assigned insurance or agency authorization or for which no prior payment arrangement has been made.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

We reserve the right, without prior notification, to change our Notice of Privacy Practices and to make the terms of any change effective for all PHI data that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a request to our Privacy Officer in writing at:

Martinsburg Family Eye Care
ATTN: Privacy Officer
55 Meridian Parkway, STE 105
Martinsburg, WV 25404

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, AND INSURANCE AUTHORIZATION. I ACCEPT ON BEHALF OF MYSELF AND/OR THE PATIENT UNDER CARE ALL THE ITEMS LISTED ABOVE IN THIS NOTICE GIVEN BY Martinsburg Family Eye Care.

Patient Signature:	Date:
Print Name:	
Witness:	Title:
If patient is a minor or unable to sign, complete the following	:
Guardian Signature:	Date:
Relationship:	
Witness:	Title: