North County Optometry
Acknowledgement and Consent Form

I understand that North County Optometry (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created by 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:

1. Make decisions about and plan for my care and treatment.
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
3. 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 health care; and
4. Perform various office, administrative and business functions that support my eye doctor'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 is 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 staff of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised periodically, and that I am entitled to receive a copy of any revision. I also understand that a copy of the most current version of This Practice's Notice of Privacy Practices will be posted in the 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. By signing my name below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient's name:_____

Name of Parent or Guardian:_____

Signature of Patient or Parent/Guardian:_____

Date: _____