Receipt of Notice of Privacy Policies & Consent Form

Kramer & Newcomb, O.D., P.C.

112 W. Commercial St	or	1350 Spur Dr., Ste 150
P.O. Box 80		P.O. Box 289
Buffalo, MO 65622		Marshfield, MO 65706
Phone: 417-345-2901		Phone: 417-468-6682
Fax: 417-345-2904		Fax: 417-859-6634

Patient Name:________________________________Phone #:________________________________

Patient Address:____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices,*** the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor processing claims or obtaining payment: (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment: (3) our submission of your health information to auditors hired by third-party payers and insurers: and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.***

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices,*** we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and other healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices*.

Signature:____ Date:________________________

If signing as a personal representative of the patient, describe the relationship to the patient and the source authority to sign this form:

____________________________________	____________________________________
Relationship to Patient	Print Name

Source of Authority:____

Voluntary Consent Form

Kramer & Newcomb, O.D., P.C.

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Consent to use or disclose health information for treatment, payment and healthcare operations.

I understand that as part of my healthcare, the offices of Kramer & Newcomb, OD, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, prescriptions for: eyeglasses, contact lenses, low vision devices and medications, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- A means by which payment for serviced can be made

I understand and have be provided with a ***NOTICE OF PRIVACY PRACTICES*** that provides a more complete description of information uses and disclosures. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and will provide a copy of any revised notice through this office in person, or by mail upon request. I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restriction on the use of my health information. I understand that my request is not agreed to by Kramer & Newcomb, OD, PC unless Kramer & Newcomb OD, PC agrees to the request in writing.

I understand for convenience or necessity I would like my health information available to the following friends or family members:

______________________________ ______________________________

______________________________ ______________________________

I fully understand and accept the terms of this contract.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

Signature:____ **Date:**____________________

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________

Relationship to Patient Print Name

Source of Authority:____