Patient Name_____ DOB:_____

PAYMENT POLICY

_____ I have received, read and understand Seaside Ophthalmology's *Payment Policy* containing a more complete description. I understand that this organization has the right to change its *Payment Policy* from time to time and that I may contact this organization at any time to obtain a current copy of the *Payment Policy.*

AUTHORIZATION FOR SERVICES

_____ The signature below serves as authorization for services rendered by Seaside Ophthalmology for the above named patient, and for release of information necessary to file insurance and assign benefits otherwise payable to policy holder, to the doctor or to the group indicated on the claim. A copy of the signature is as valid as the original.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I authorize Seaside Ophthalmology to disclose my protected health information to:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

This authorization for release of information covers the period of healthcare from:

□ _____ to _____ - OR - □ all past, present and future periods.

_____ I have received, read and understand Seaside Ophthalmology's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Signature:_____ Date:_____