BLUESTEIN
CUSTOM VISION
www.bluesteinvision.com
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2287 Henry Tecklenburg Drive
Charleston, SC 29414

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

WHAT IS THIS NOTICE ABOUT AND WHY IS IT IMPORTANT

This notice is required by the U.S. Department of Health and Human Services in order for me to be informed of how my health information will be used, disclosed, and protected, and about my rights regarding my health information. I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information (PHI).

I understand that this information can and will be used:

- **For Treatment:** We are permitted to use your health information or disclose it to others outside Bluestein Custom Vision, in order to provide, plan and direct proper medical care for you.
- **For Payment:** We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you received, and collect payment from you, you insurance company or a third party payer.
- **For Health Care Operations:** We are permitted to use your health information to assess the care and outcome in your case and others like it, in order to assure the highest quality of care for out patients.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your **Notice to Privacy Practices** containing a more complete description of the uses and disclosures of my PHI is available to me. 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.**

***** I authorize / I DO NOT authorize Bluestein Custom Vision, to release my**
(Please Circle One)
protected health information to family members. ***

Patient name:_____ DOB:_____
Signature (of Patient or Legal Guardian):_____
Date:_____

Practice Use Only

I attempted to obtain the signature of the patient or legal guardian in acceptance of the Notice Of Privacy Practices acknowledgement but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

I understand that it is the patient's responsibility to supply BLUESTEIN CUSTOM VISION, with any current insurance information and / or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my insurance may not cover this appointment. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees. I authorize Bluestein Custom Vision, to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. **I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.**

I understand that Medicare and most insurance companies do not cover standard care or eye refractions (eyeglass prescriptions) and that I will be fully responsible for these charges. I understand that insurance companies require beneficiaries to pay deductibles and, company insurance, co-payments, and any non-covered services at the time services are rendered.

Most insurance companies do not cover the contact lens fitting or contact lens modification. The contact lens modification is a yearly charge that is separate from the eye exam charge. I understand that I am responsible for this additional charge.

I understand that a comprehensive eye exam involves dilation of the pupil, which may temporarily blur my vision for several hours. I recognize that operations of a motor vehicle after dilation may be hazardous and have made appropriate arrangements.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, MC, VISA, AMERICAN EXPRESS, AND DISCOVER.

1) Date:_____ Signature:_____

I authorize Bluestein Custom Vision, to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of Bluestein Custom Vision to furnish information to insurance carriers or other doctors concerning my illness and treatment. They may also obtain pre-certifications and prior authorizations when necessary.

2) Date:_____ Signature:_____

Reviewed by:_____