Montgomery Eye Physicians & Surgeons

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Use and Disclosure of Protected Health Information
PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Our **Notice of Privacy Practice** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

____________________ Please acknowledge receipt of our **Notice of Privacy Practices**
Patient's Initials by initialing in the space provided.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. We will mail to your home a recall card to notify you that you are due for another appointment. You have the right to revoke this consent in writing, except when we have already made disclosure in trust on your prior consent.

I request the payment authorized Medicare/Insurance carrier benefits be made on my behalf to **Montgomery Eye Physicians & Surgeons, P.A.** for any service furnished to me by that physician or supplier. I authorize any holder of medical information about me to be released to the Centers for Medicare/Medicaid Services and it's agent and/or any other insurance carriers for which have coverage, any information needed to determine these benefits or the benefits payable for related services, I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at time of service in accordance with the contracted insurance carrier agreements.

In order for our office to effectively communicate with you, please complete the following. You may update your selections at any time.

Please indicate below who we may discuss your medical information with. Include the individual name, relationship to you, and phone number. The individual listed will only be contacted with your consent.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Please initial below if you would like a detailed message via phone:

__________ I consent to staff (physicians, technicians, or office personnel) of Montgomery Eye Physicians & Surgeons, P.A. to leave voicemails on my phone regarding my care and/or test results.

__________ I consent to staff (physicians, technicians, or office personnel) of Montgomery Eye Physicians & Surgeons, P.A. to leave voicemails on my phone regarding appointment requests.

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Patient's Signature Date

____
Print Full Name