HIPAA:

I acknowledge that the Notice of Privacy Rights (HIPAA) has been made available for my review and I give Oculoplastic Associates of Texas my permission to use and disclose my health information in accordance with it.

_____ Initials

Please list any person, if any, whom we may inform about your general medical condition and diagnosis (including treatment, payment, and health care operations):

Name: ________________________________ Phone #: ____________________________

Name: ________________________________ Phone #: ____________________________

Name: ________________________________ Phone #: ____________________________

Name: ________________________________ Phone #: ____________________________

Can confidential messages (i.e., appointment reminders) be sent to your voicemail and email?

_______ Yes _______ No

Photography and Your Insurance:

Unfortunately, some insurance companies will not compensate for the expenses associated with these photographs. Should they not cover photography under the benefits of your plan, you will be responsible for a $30.00 photography fee.

_____ Initials

Authorization for Patient Photography:

I hearby authorize Oculoplastic Associates of Texas to photograph the ophthalmic condition for which I am seeking care. I understand these photographs are often necessary documentation of my medical condition and are needed by the insurance companies for verification or to be used for teaching purposes.

_____ Initials

ERX Consent:

I agree that Oculoplastic Associates of Texas may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ Initials

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION

________________________________ ________________________________

PRINTED NAME PATIENT DATE OF BIRTH

________________________________ ________________________________

SIGNATURE DATE