RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

ARTESIA I CARE OPTOMETRY
DR. BRYAN IMOTO OD & ASSOCIATES
11436 ARTESIA BLVD. SUITE D
562.860.1717

Patient Name _____ **Date of Birth** _____

Address _____ **City/Zip Code** _____

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information on 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 describe 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 services provided here, but also disclosure of your health information 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 for processing claims or obtaining payment, (2) our submission of claims to a third party payer or insurer for claims review, determination of benefits and payments, (3) our submission of your health information to an auditor 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 may obtain an updated copy at our 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 of disclosure made for purposes of treatment or payment of healthcare operations, but as described in out Notice of Privacy Practices, we are not obligated 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 restriction.

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

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 _____