PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				DATE		
STREET ADDRESS				SS#		
CITY				SPECIAL NEEDS ☐ WHEEL CHAIR ☐ HEARING IMPAIRED ☐ OTHER _____		
STATE	COUNTY	ZIP CODE	BIRTHDATE	AGE	RACE	SEX
HOME / CELL PHONE ( ) -	WORK PHONE ( ) -		MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED			
EMPLOYER NAME / ADDRESS			EMAIL ADDRESS			
SPOUSE			SPOUSE'S WORK PHONE ( ) -			
EMERGENCY CONTACT			EMERGENCY PHONE ( ) -			

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
STREET ADDRESS		PHONE ( ) -	
CITY		STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID #	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID #	INSURED'S DOB
SEND WORKER'S COMPENSATION TO	AUTHORIZED BY / POSITION	DATE OF INCIDENT	

REFERRAL

WHO REFERRED YOU TO OUR PRACTICE? NAME	☐ FRIEND / FAMILY ☐ PROLOGUE ☐ NEWSPAPER _____ ☐ PATIENT ☐ SIGN ☐ RADIO _____ ☐ YELLOW PAGES ☐ OTHER _____		
FAMILY OPTOMETRIST NAME			
PHONE ( ) -	☐ MD / DO _____ ☐ OPTOMETRIST _____		
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR NAME	PHONE ( ) -		
STREET ADDRESS	CITY	STATE	ZIP CODE

Health History

Yes No

- □ □ **Asthma** _____
- □ □ **COPD** _____
- □ □ **Tuberculosis** _____
- □ □ **Diabetes: Type I _____ / Type II _____# of yrs____**
- □ □ **Insulin Dependent** _____
- □ □ **Kidney Disease** _____
- □ □ **Psychiatric Disorder** _____
- □ □ **Any nervous disorder** _____
- □ □ **Alzheimer's** _____
- □ □ **Dementia** _____
- □ □ **Heart Disease** _____
- □ □ **High Blood Pressure** _____
- □ □ **Carotid Artery Disease _____ # of yrs _____**
- □ □ **Stroke** _____
- □ □ **High Cholesterol** _____

Yes No

- □ □ **Migraines** _____
- □ □ **Head or Spinal Injuries** _____
- □ □ **Seizures, Convulsions, or Fainting** _____
- □ □ **Diagnosed with Cancer** _____
- □ □ **Allergy to Iodine** _____
- □ □ **Allergy to Latex** _____
- □ □ **HIV/AIDS** _____
- □ □ **Hepatitis** _____
- □ □ **Dental Cavities?** _____
- □ □ **Suffering from any other disease** _____
- □ □ **Are your immunizations current?** _____
- □ □ **Do you consume alcoholic beverages?** _____
- □ □ **Current smoker? / Former smoker? ____# of yrs quit**
- □ □ **Within the last twelve (12) months have you taken any illegal substances?** _____

Please list ALL medications AND dosages you are currently taking. (Include vitamins, eye drops, and over the counter medications)

Name of medication	*Dosage*	*Name of medication*	*Dosage*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list ANY allergies to medications AND reactions:

Name of medication	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with the following in the past?

Yes No

- □ □ **Cornea Disease**
- □ □ **Glaucoma**
- □ □ **Macular Degeneration**
- □ □ **Iritis**
- □ □ **Diabetic Retinopathy**
- □ □ **Cataracts**
- □ □ **Amblyopia (Lazy Eye)**
- □ □ **Retina Disease**

Surgical Ocular History

	Right eye	*Left eye*
Cataract Surgery: Date:	_____	_____
Retina Surgery: Date:	_____	_____
Lasik Surgery: Date:	_____	_____
Cornea Surgery: Date:	_____	_____

Eye Injuries (Please include Date and type of injury)

_____
_____
_____

YOUR SURGERY HISTORY *(Please include Date & Type)*

_____
_____
_____

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?)

(PLEASE NOTE RELATION TO PATIENT) **M –Mother F- Father S-Sister B-Brother GF-Grandfather GM-Grandmother U-Uncle A-Aunt**

Yes No

- □ □ _____**Diabetes**
- □ □ _____**Diabetic retinopathy**
- □ □ _____**Cataracts**
- □ □ _____**Retinitis Pigmentosa**
- □ □ _____**Macular Degeneration**
- □ □ _____**Heart Disease**
- □ □ _____**Glaucoma**
- □ □ _____**Cornea Disease**
- □ □ _____**Retinal Detachment**
- □ □ _____**Stroke**
- □ □ _____**Other Eye Problems**
- □ □ _____**Other General Health Problems**

Social History *(circle one)*

Are you currently: *Married / Widowed / Single / Divorced*

Living Conditions: *Lives alone / Lives in Nursing Home / Lives with caretaker, family, or spouse*

Driving*: Yes No*

Occupation: _____

Patient Signature:_____ ***Date:***_____

Wiles Eye Center

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductible and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Wiles Eye Center for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer or employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.
I hereby authorize payment of my Medigap benefits to PWiles Eye Center, for all claims filed on my behalf.

Receipt of (Notice of Privacy Practices written acknowledgement form)

□ I, _____, have received a copy of **Wiles Eye Center** Notice of Privacy Practices

□ I, _____, refuse to accept a copy of **Wiles Eye Center** Notice of Privacy Practices

This agreement is in effect until revoked in writing by the patient or their representative

Signature of Patient_____ Date_____

Notice of Privacy Practices

Wiles Eye Center

Effective Date: *September 23, 2013*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.**

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information

with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release

Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.** We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.**

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.**

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family

member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.** We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.** Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.perfectsense.net. To obtain a paper copy of this notice, **Privacy Officer, 211 NE 54th St. Suite 202, Kansas City, MO 64118.**

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **Privacy Officer, 816-455-2020**. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

Wiles Eye Center

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

And

Patient Consent for Use and Disclosure of

Protected Health Information

I, _____, have received a copy of Wiles Eye Center Notice of Privacy Practices.

I hereby give my consent for Wiles Eye Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, or health care operations as described in the Notice of Privacy Practices that I have been provided.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wiles Eye Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wiles Eye Center, Attn: Privacy Officer, 211 NE 54th Street Ste 202 Kansas City, MO 64118.

I have the right to request that Wiles Eye Center restrict how it uses or discloses my PHI to carry out treatment, payment or health care operations. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wiles Eye Center may decline to provide treatment to me.

_____ _____

Signature of Patient Date

Wiles Eye Center

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") provide you the right to request that Wiles Eye Center communicate with you about your health information at an alternative address or phone number, or by an alternative means (for example, by email) that is more confidential for you. Wiles Eye Center must accommodate your request if it is reasonable. Wiles Eye Center may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, Wiles Eye Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.

To request confidential communications, please complete the form below and send to: Privacy Officer, 211 NE 54th Street Suite 202 Kansas City, MO 64118.

_ _

Patient Name (print): ____

Patient Address: ____

Phone Number: ___________________________ Email:____________________________

Describe the alternative means of communication you are requesting:

____

____

____

____

I am requesting that Wiles Eye Center communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me.

I understand that the Wiles Eye Center will not accommodate unreasonable requests. The Wiles Eye Center will notify me within thirty (30) days of its decision.

Signature: ____________________________________ Date: _______/_______/________

Name of personal representative (if applicable): ____

Personal representative's authority (supporting documentation required):
Parent Guardian Health Care Agent Administrator/Executor

Other: ___________________________________

Office Use: Received: ____/_____/_____
Completed: ____/_____/_____
Initials: ______________

Wiles Eye Center

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you and pursuant to our general Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Specific description of the information to be used or disclosed, including the specific purpose:

All or specify _____

Individuals who may use or disclose this information: **Wiles Eye Center**.

Individuals who may receive and use the disclosed information: _____
Please mark if you give authorization for our office to leave a message regarding the above information ↑
Yes ↑No
If yes what Phone Number would like our office to use _____

Expiration date of the authorization (if needed): DATE: ___/___/_____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer or the Practice.

This authorization was signed by: _____ DOB:_____

Printed Name of Patient or Representative_____

Patient's Date of Birth _____ Date:_____

Wiles Eye Center
Marketing and Promotional Communication Consent

Marketing Products or Services: "Marketing" means to make a communication to you that encourages you to purchase or use a product or service. We will not use or disclose your health information for marketing communications without your prior written authorization. However, we may conduct face to face communications between you and us, and we may offer a promotional gift of nominal value, without such authorization.

We may also provide you with information regarding products or services that we offer related to your health care needs provided that we are not paid or otherwise receive compensation for such communications.

We are also permitted to communicate with you regarding health-related products or services (including information about entities participating in our provider network or health plan), treatment, case management or care coordination (including recommending alternative treatments, providers or settings for care). However, if we will receive compensation (directly or indirectly) in return for making any such communications, we must first obtain your written authorization, unless the communication describes only a drug or biologic that is currently prescribed for you and any compensation we receive relates solely to the cost of making the communication. This requirement does not apply to any payment or compensation for providing treatment to you.

Sale of Your Health Information: We will never sell your health information without your prior authorization. However, we, or our business associate, may receive compensation (directly or indirectly) related to an exchange of your health information for the following purposes: (a) public health activities; (b) research purposes (if the price charged reflects the cost of preparation and transmittal of the information); (c) payment or compensation for your treatment; (d) health care operations related to the sale, merger or consolidation of all or part of our business; (c) performance of services by a business associate on our behalf; (f) providing you with a copy of your health information; or (g) other reasons determined necessary or appropriate by applicable laws or regulations.

By signing below I agree to allow Wiles Eye Center to communicate with me about marketing and promotional offers in addition to appointment reminders and health-related products and services.

_____ _____
Printed Name Email Address

_____ _____
Signature Date