NOTICE OF PRIVACY PRACTICES RECEIPT & CONSENT FORM
GILMAN & VORSTER OPTOMETRY, INC.

Jennifer A. Gilman, O.D.
Grant Vorster, O.D.
81833 Dr. Carreon Blvd., Suite 5, Indio, CA 92201
Phone: 760-863-2241 Fax: 760-863-1919

Patient Name _____ Date of Birth _____

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as 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 third-party payers or insurers for claims review, determination of benefits and payment: (3) our submission of your health information to auditors 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 or as laws change that may affect you. You can get an updated copy here at our office.

By law, we must abide by the terms of our *Notice of Privacy Practices* until we choose to change it. We reserve the right to change our *Notice of Privacy Practices* at any time in compliance with and as allowed by law. If we change our notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our *Notice of Privacy Practices*, we will post the new notice in our office, as well as have copies available upon request.

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 may obtain a copy of our complete privacy statement from our office and, in fact, we encourage you to do so. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged 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 a restriction.

I consent to the use and disclosure of my health information or that of my child, including the release of the diagnosis and records of any treatment of any examination during the period of such care for the purpose of treatment, payment, and healthcare operations. I am aware that upon a request a copy of the entire *Notice of Privacy Practices* for this office will be given to me.

I authorize and request my insurance company to pay directly to Gilman & Vorster Optometry insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read this document and understand it.

Patient Name _____ 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 _____ Print Name _____