



**NOTICE OF HIPAA**

HIPAA stands for the Health Insurance Portability and Accountability Act. A U.S. Law that took effect in 2003 to put privacy standards in place. The law protects patients' medical records and other health information given to health plans, doctors, hospitals, and other healthcare providers. The standards give patients better access to their medical records and more control of how their personal health information is used and controlled.

As such, you can expect your optometrist or optician to do the following under HIPAA. They are required by federal and state law to:

- Maintain privacy and safeguard the security of your health information.
- Provide notice about privacy practices, legal duties, and your rights concerning all your health information.
- Notify you of breaches of unsecured health information.

If there are any questions about HIPAA compliance or you have any questions, you can always ask office staff to provide you with the information you need. Ongoing compliance training is the most initiative-taking way a provider can avoid a violation. All employees must have adequate and ongoing HIPAA awareness training to ensure ongoing accountability for compliance with privacy and security policies and procedures regarding patients.

At Freedom Optical, we are fully compliant with HIPAA and strive to protect your privacy in accordance with the law. Upon arrival at our office, we will provide a form for you to complete and update and review on each annual visit.

**VERBAL PERMISSION OR CHANGE IS NOT ACCEPTABLE AT ANY TIME.**

***This includes the dispensing of Eyeglasses, Sunglasses and Contact Lenses.***

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**Consent to Release:**

I have read the above regarding my option to give others permission to obtain my records, products and materials from Freedom Optical.  
Please list the names below and sign acknowledgement of receiving HIPAA information and the opportunity to release my information with Freedom Optical to the names below. ALL THE CHANGES MUST BE IN WRITING. Freedom Optical does not sell your information to third parties and treats it with privacy.

**Must be 18 years old to be on consent form:**

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Patient Print Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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**Parental/ Guardian Consent for Minors:**



I, \_\_\_\_\_, authorize Freedom Optical to provide eyecare products to services to the minor: (dispense and fitting of eyeglasses. eyeglass adjustments, repairs, or picking up contact lenses.

Parent / Guardian Signature: \_\_\_\_\_

**Patient Information Form**

**Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**DL #** \_\_\_\_\_

**Vision Plan Name:** \_\_\_\_\_ **ID/ SS#** \_\_\_\_\_

**Primary Insured Name:** \_\_\_\_\_ **D. O. B.** \_\_\_\_\_

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**Financial Agreement:**

\_\_\_\_\_ I understand that my vision plan is **IN NETWORK**, any cost denied for any reason by my insurance will be due from the party responsible. All co-pays and payments are due at the time of service.

\_\_\_\_\_ I understand that with **VSP**, Freedom Optical is an **OPEN NETWORK**, which allows my use of my out of network benefits with additional instant savings. Reimbursement will be paid to Freedom Optical. Freedom Optical is not financially liable if my plan does not reimburse for out-of-network benefits and all payment is due at the time of service and before any products are ordered.

\_\_\_\_\_ My plan is **OUT- OF -NETWORK**. I understand that Freedom Optical will provide an itemized receipt. It is my responsibility to file and follow up with my insurance on the claim status. directly with my insurance company. Freedom Optical is not financially liable if my plan does not reimburse for out-of-network benefits and all payment is due at the time of service and before any products are ordered.

\_\_\_\_\_ **Verification of benefits IS NOT a guarantee of payment from the insurance company.** Insurance must be provided before an appointment to allow proper time for verification. Billing and Payment adjustments will not be changed after the closing day on the original date of service.

**Permission to Use Photograph**



I, the undersigned, hereby grant Freedom Optical, Inc. the absolute right and permission to use my photograph(s) in any manner or media, including, but not limited to, the following purposes:

educational presentations, publications, advertising and promotional materials, social media platforms, AND websites.

Press releases

\_\_\_\_\_ Yes, I consent

\_\_\_\_\_ No, I do not Consent Patient

Signature: \_\_\_\_\_