## **Privacy Policy and Confidential Communication Form**

## **HIPAA (Privacy Policy) Acknowledgment**

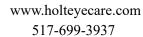
Found on the back and on our website.

I acknowledge to have received a copy of the HIPAA Privacy Policy of this office and have read, understood, and agreed to all the information.

Print (Patient/Responsib	le Party):				
Sign (Patient/Responsibl	e Party):				_
Patient's Date of Birth:	//		Today's	Date:/	/
I authorize the release of individuals (Please put N			_	e or in-person to	the following
1. Name of person:			_ Relationship:	, •	
Primary contact	number:		-		
2. Name of person:					
Relationship:		Primary	contact numbe	r:	
With the use of E	lectronic Healt	*	O	-	•
RACE:					
American Indian	Black Na	tive Hawaiian	Asian	Caucasian	Other
ETHNICITY:					
Hispanic or Latino	Not Hispan	ic or Latino	No	o Answer	
PREFERRED LANGU	AGE:				
American Sign Language	e Arabic	English	French	German	Italian
Korean Polish	Spanish				
HEIGHT:ftin		WEIGHT:_	lbs		

☐ Spartan Eyecare

☐ Draper Eyewear





## **Electronic Communications & Billing**

Holt Eye Care, PLLC utilizes a third-party electronic communication system. These communications will be used for scheduling, reminders, and also for collecting or sending pertinent clinical, insurance information, invoices, billing &/or collections information as is necessary to provide your treatment and/or to correspond. I understand that communications via the means as described above are not always secure. Although it is very unlikely, there is a possibility that information you or we send may be intercepted or it may also be read by other parties besides the person to whom it is addressed. Moreover, I understand that by federal law, Holt Eye Care, PLLC may not use/disclose my healthcare information without my authorization.

	ent/Responsible Party Signature:e:
	se provide a primary <u>email address</u> & <u>phone number</u> for any updates, newsletters, billing, and idential communications.
E-m	ail:
Pho	ne Number:
	Please circle your <u>preferred</u> type of communication: Home Cell/Text Email
	By signing, I acknowledge and understand:
	nent for all services and products is the responsibility of the patient. I agree to pay all copays, deductibles, asurances and non-covered services as determined by my insurance company.
notif be ac	afirm that I have received a digital copy of my prescription upon completing my examination through fication from MySecureHealthData.com that your eyeglass and/or contact lens prescription is available and can excessed, viewed, downloaded and/or printed. If I wish to obtain a physical copy of my prescription, I understand I will need to request it at the time of checkout or contact the office in the future.
I und	derstand there is a returned check fee applied to every returned check.
	horize the release of medical information concerning my illness and treatment by Holt Eye Care, PLLC to my rance company.
I also	authorize the release of my personal medical information to any doctor whom I may be referred to.
A res	stocking fee may apply to any returned glasses and/or contacts due to the item(s) being a customized product
I und	derstand verification of eligibility is not a guarantee of payment as stated by my insurance company.
I aut	horize payment of my insurance benefits to Holt Eye Care, PLLC.
t/Res	ponsible Party Signature: Date:/
1	If you're new to Holt Eye Care, we would love to know how you heard about us!
	☐ Word of Mouth ☐ Social Media ☐ Digital Advertising

☐ Other: