BRIDGEPORT
FAMILY VISION CLINIC

9101 Bridgeport Way SW, Suite C, Lakewood, WA 98499
Dr. Brett Igbinoba ● Dr. Jeremy Whitney

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ________________________________

Date: ______________

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I hereby authorize___________________________to obtain my medical information.

How is this person related to you?____

<u>For Office Use Only</u>

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but written acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining written acknowledgements**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (please Specify)**

<u>Please Read:</u>

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. I understand that all benefits quoted to me are not a guarantee of payment by my insuraance company and that final determination can only be made when the claim is processed. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. I understand (even if I do not have insurance) that I will be financially responsible for payment of all charges incurred for services from this clinic. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefit either to myself or to the party who accepts assignment. I authorize payment of medical beneftis to the physician or supplier for the services rendered.

____ ____________________

Signature **Date**