ACUITY VISION CENTER

Patient Information: **Welcome To Acuity Vision Center**

Name:	Preferred Name:	Birthdate:	Gender: □ male □ female
Address:			
Tel (home):	Tel (cell):		Race:
Email:	Preferred Language: □ English □ Other:		
Occupation:	Employer:		Tel (work):
Family Doctor:	Family Doctor Phone:		Family Doctor Fax:
How did you hear about us / referred by?			

CONSENT FOR TREATMENT: I authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.
E-Prescribing Consent: Ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Fill Status Notification** : Allows the prescriber to receive and electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- **Formulary and benefit transactions** : Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** : Provides information about medications already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Acuity Vision Center, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.
Understanding all of the above, I hereby provide informed consent to Acuity Vision Center, LLC to allow medication history to be obtained on my behalf and to utilize E-prescribing for purposes outlined above.

_____ {DATE_TODAY}

signature of patient or patient's representative ☐ I decline to receive communication by Email and phone

Responsible Party (insurance subscriber):

Name:	Birthdate:	Relationship:

Vision Insurance Information:

Insurance company:	Insurer ID:	Group #:

Medical Insurance Information:

Insurance company:	Insurer ID:	Group #:

ACKNOWLEDGMENT AND CONSENT:
*I understand and agree that **Acuity Vision Center, LLC.** may use and disclose my **health information** to:*

- *Make decisions about and plan for my care and treatment;*
- *Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;*
- *Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and*
- *Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.*

***I** understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.*
***I** also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made how it is used by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.*
***I** understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and is available to me.*
***I** understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.*
By signing below, I agree that I have reviewed and understand the information above and that a copy of Notice of Privacy Practice is available to me.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, co-pay or other balance not paid by my insurance. I authorize insurance benefits to be paid directly to the provider.
I also understand that Examination and Professional Services Fees are Non-Refundable once prescription is finalized.

_____ {DATE_TODAY}

signature of patient or patient's representative ☐ I decline to sign acknowledgment and consent; please state reason: