CERES EYE CARE

ACKNOWLEDGEMENT AND CONSENT

I understand that Ceres Eye Care will use and disclose health information about me. 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 type of health related information.

It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving Ceres Eye Care.

I understand and agree that Ceres Eye Care may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage, along with other healthcare providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bill, claims, and other related information to insurance companies or others who may be responsible to pay some of my health care
- 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 health care

I also understand that I have the right to receive and review a written description of how Ceres Eye Care will handle health information about me. This written prescription is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Ceres Eye Care, 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. I also understand that a copy or summary of the most current Notice of Privacy Practices will be posted in waiting/reception area.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: ..... Date: .....

(Patient)

-OR-

By:..... Date: .....

(Patient Representative)

Description of Representative's Authority:.....

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Ceres Eye Care on my behalf for any services or materials furnished. I authorize any holder of medical information about me to release to the Health Care financing administration and its agents any information needed to determine these benefits payable to related services. If I have any other health insurance coverage (as indicated in item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above.

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Lifetime patient signature Date