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/Responsible Party):_____

Sign (Patient/Responsible Party):_____

Date: _____/_____/_____

I authorize the release of my protected health information over the telephone or in-person to the following individuals (Please put N/A over this section if not applicable):

1. Name of person:_____ Relationship:_____
   Primary contact number:_____
2. Name of person:_____
   Relationship:_____Primary contact number:_____

(Note: If communication with primary doctor or referring doctor is needed, no additional authorization is required)

Electronic Health Record

With the use of Electronic Health Records, the government now requires every medical office to ask the following questions, it is *optional* to answer.

RACE:

American Indian Black Native Hawaiian Asian Caucasian Other

ETHNICITY:

Hispanic or Latino Not Hispanic or Latino No Answer

PREFERRED LANGUAGE:

American Sign Language Arabic English French German Italian

Korean Polish Spanish

HEIGHT: ____ft____in **WEIGHT**:_____lbs

2040 N. Aurelius Ste. 20
Holt, MI 48842

www.holteyecare.com
517-699-3937

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.

Patient/Responsible Party Signature: _____

Date: _____/_____/_____

Please provide a primary email address & phone number for any updates, newsletters, billing, and confidential communications.

E-mail: _____

Phone Number: _____

Please circle your preferred type of communication: Home Cell/Text Email

By signing, I acknowledge and understand:

Payment for all services and products is the responsibility of the patient. I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I authorize the release of medical information concerning my illness and treatment by Holt Eye Care, PLLC to my insurance company.

I also authorize the release of my personal medical information to any doctor whom I may be referred to.

A restocking fee may apply to any returned glasses and/or contacts due to the item(s) being a customized product

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Holt Eye Care, PLLC.

Patient/Responsible Party Signature: _____

Date: _____/_____/_____

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
Spartan Eyecare Draper Eyewear Other