

# WELCOME TO OUR OFFICE

## Ashland Optometric Clinic

### Family Eye Care

Thank you for choosing **Ashland Optometric Clinic!** Our goal is to provide you with the most complete and advanced primary eye care available, by choosing state of the art technology with quality clinical care. We continually strive to fulfill your eye care needs and surpass your expectations. Dr. Kenneth L. Harris O.D. and staff will strive to ensure a pleasant and caring experience. We look forward to serving you!

### ACKNOWLEDGEMENT & CONSENT

I understand that **Ashland Optometric Clinic** (referred below as "this practice") 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, examination, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this practice 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 health care providers for my care and treatments:
- 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:
- 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 this practice will handle health information about me. This written description is known as a **Notice of Privacy Practice**, and describes the uses and disclosures of health information made and the information of this practice and my rights regarding my health information.

I understand that the Notice of Privacy and 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 a summary of the most current version of this practice's Notice of Privacy Practices in effect will be posted in the reception area and available on the practice's website at: [www.ashlandoptometric.com](http://www.ashlandoptometric.com)

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 Private 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 I have received a copy of the Notice of Privacy Practice, if requested.**

Signature \_\_\_\_\_ date \_\_\_\_\_ :

Patient Representative \_\_\_\_\_ date \_\_\_\_\_ :

#### OUR PAYMENT POLICY

1. Examination fee is due at the time of service.
2. Balance of account is due at dispensing.
3. Ophthalmic purchases are due upon delivery.
4. A \$25.00 charges for all returned checks.

#### METHOD OF PAYMENT (circle one)

Cash      Visa      Master Card      Check

Insurance \_\_\_\_\_ :

Circle one if used:      Medicare      Medicaid

I have read and understand the above payment policy and payment options:

Signature \_\_\_\_\_ date \_\_\_\_\_ :