Gailey Eye Clinic, LTD.
1008 N. Main St.
Bloomington, IL 61701
(800) 325-7706

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

MRN# _____

Patient Name: _____ **Date of Birth:** _____
(Please print)
Email: _____ **Today's Date**: _____

I understand…

- That under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.
- That Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.
- Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur has a detailed document called the ***'Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.
- That I have the right to read the '*Notice'* before signing this agreement. If I ask, Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur will provide me with the most current *Notice of Privacy Practices.*
- Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur's policy is to call patients by their first and last names.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur to use and disclose my protected health information to carry out treatment, payment, and health care operations, including release of medical information to my insurance/Medicare carrier to determine benefits payable for related services. I understand that I am financially responsible to the clinic for any charges covered by **t**his authorization. Some routine eye-care costs (i.e. refractions) are generally not covered by insurance/Medicare. I understand that these costs are my responsibility. In the event collection efforts become necessary I agree to pay all reasonable collections costs up to 40% of the amount owed, plus reasonable attorney fees and court costs. I have the right to revoke this consent in writing at any time, except to the extent that Gailey Eye Clinic, LTD./Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Print Name **Relationship to Patient**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at anytime by contacting: Gailey Eye Clinic, LTD., 1008 N. Main St., Bloomington, IL 61701 800-325-7706.

***ADDITIONALLY, you grant Gailey Eye Clinic, LTD/Bloomington Eye Institute, LLC/Gailey Eye Surgery - Decatur** (circle selections below)…

Permission to leave a message on your answering machine and/or voice mail YES or NO
(This would be the phone number recorded in the chart unless another one is specified)

Permission to discuss your health care issues with your spouse or other designated person YES or NO

**If yes, please list additional designated individuals:

Name (Please Print)	**Relationship to patient**	**Phone Number**