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:** _____

Email: _____

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.

Please fill out the following:

May we leave a message via:

Call	YES	NO	If yes, cell phone number: _____
Text	YES	NO	If yes, cell phone number: _____
Email	YES	NO	If yes, email address: _____

May we discuss your health care issues with a family member or other designated person? **YES or NO**

If YES, please list family member or designated persons allowed to receive information:

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

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 this 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**

_____ _____

Legal Custodian/ Authorized Representative 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.