Receipt of Notice of Privacy Policies and Consent Form

Dr. Pauline L. Nguyen, O.D. & Associates, P.A.
11602 Lake Underhill Rd, Suite 103, Orlando, FL. 32825
Phone : (407) 381-7001, Fax : (407) 381-7004

In the course of providing service to you, we create, receive, and store health information that identifies you. 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 health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form or to receive a copy of this Notice. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information for treatment purposes not only including disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices.**

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses and disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from the office of Dr. Pauline Nguyen, O.D. and I have been provided an opportunity to review it.

(Please print "**PATIENT**" full legal name):_____

SIGNATURE:_____DATE:_____
(Parent or guardian's signature if the patient or child is under 18 years of age)

_____ _____
Relationship to Patient **Print full name**

Notice of Privacy Practices

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Phone : (407) 381-7001, Fax : (407) 381-7004
visioneyegallery@gmail.com **Contact Person : Pauline Nguyen, O.D.**

DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Typically, we will use or disclose your health information for treatment, payment, and health care operations. We will use your healthcare information inside our office without any special permission from you. If we should need to disclose your health information outisde of our office for treatment, payment, or health care operations, we will not ask you for special wrtitten permission. Treatment, payment, and health care operations include, but are not limited to, discussing your health with another doctor or their office, releasing records to your insurance company, and contacting you by phone or mail with an appointment reminder.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

It is possible, in some rare circumstances, that we may release your personal medical information without your permission when required to do so by law. We will release information when required under court order, for law enforcement purposes, or when audited by your insurance company. It is possible that your medical information could be disclosed in a de-identified form to assist in medical research, for contagious disease reporting, to report dangerous drug interactions, or to report injury from a medical device to the proper government agency.
We may report your medical information without your permission to the proper authorities if we suspect that a crime has been committed, will be committed, or if we suspect that a patient has been abused.

HOW OUR OFFICE MAY CONTACT YOU

Our office may contact you form time to time concerning your care. We may contact you by mail, phone, or email. We may contact you regarding your next appointment, to inform you that your order is ready, to pay an outstanding balance, or to market services in our office.

WHEN YOUR PERMISSION IS REQUIRED

We will not make any other disclosures or use of your health information without your written permission. If you would like us to send your information to another office, you must sign a form authoring the relase of medical records. If we decide to use your information in any manner that does not involve treatment, payment, health care operations or one of the other reasons already stated, then we will request your permission in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to ask us to restrict our use and disclosure of your personal and health information to purposes of treatment, payment, or health care operations. You also have the right to request that we communicate with you in a confidential manner. You have the right to request photocopies of your health information. You have the right to ask us to amend your health information. You have the right to request a list of all disclosures of your health information that were unrelated to treatment, payment, or healthcare operations. You have the right to request additional copies of this privacy notice.

In some circumstances, we are not required to comply with your requests. However, we will make every attempt to comply with all reasonable requests. If we decided not to comply with your request you will receive a written explanation for our decision with 30 days. You may be required to pay for any costs incurred by your request for special handling of your health information. In most cases, we are allowed 30 days to respond to any requests that a patient may have regarding their health information.

OUR PRIVACY PRACTICFES

By law, we will follow the terms of this privacy policy until such time as we decide to change it. We are permitted, by law, to change the policy at any time without prior notice. If the policy is changed, it will be posted in our office and copies will be available for patients to take home.

COMPLAINTS

If you believe that we have not properly protected the privacy of your information, you are free to file a complaint to Dr. Pauline Nguyen, or to the U.S. Department of Health and Human Services, Office for Civil Rights.