In the event that it becomes necessary for us to release your records to or request from another healthcare professional, I authorize Optic Gallery to release and/or request these records. If applicable, I request payment of authorized Medicare or other insurances be made either to me or on my behalf to Optic Gallery, for any service rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.
I understand that I am responsible for any charges not covered by my insurance company. It is the policy of this office to require: 1) payment in full or at least one-half deposit made before an order can be placed. 2) the balance of the fee must be paid at the time the order is dispensed. 3) all orders are final when placed. I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services rendered "Optic Gallery" may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court costs incurred in collection of my overdue account.

Signature_____ **Date** _____

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

Signing in this section signifies that you have received a copy of our Notice of Privacy Practices

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 thes services and to conduct healthcare operations involving our offices.
The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Signature (patient or guardian) _____ Date _____

DILATION OF THE EYES

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the internal health of the eyes. The dilating drops typically last 4-6 hours. During this time you may find it difficult to focus at near and less commonly, at distance. You may be sensitive to light. You will be provided with post-dilation glasses.
We strongly recommend caution when driving or operating equipment or machinery after dilation.
Signing this section signifies that you have been informed of the risks and benefits of dilation.

Please select one of the options below, indication your choice for Dilation:

☐ I wish to have Dilation performed today ☐ I do not wish to have dilation performed today

☐ I wish to discuss Dilation with the doctor to help with my decision

DIGITAL COMMUNICATION

I give permission to be in contact via text message, email, and/or Patient Portal with our Electronic Medical Records System.

Signature (patient or guardian) _____ Date _____

OPTIC GALLERY
Family Eye Care

Optic Gallery Skye Canyon, LLC
9560 W Skye Canyon Park Dr. #180 Las Vegas, NV 89166
(702) 872-2020

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change and if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information (PHI) is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, and healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with a member of your family? YES NO
If yes, please name the members allowed:

This consent was signed by (Print name): _____

Signature: _____ Date _____

Witness _____ Date _____

Optic Gallery Skye Canyon, LLC
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