PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed for treatment, payment or health care operations. The complete **NOTICE OF PRIVACY PRACTICES** of **CENTRAL FLORIDA EYES, INC**. is available upon request for your review. **CENTRAL FLORIDA EYES, INC**. may use and disclose your medical records only for each of the following purposes:

1. **TREATMENT**: Includes providing, coordinating and managing your medical records to consulting clinicians and insurance companies. For example EYE EXAM; OR REFERRING YOU TO ANOTHER CLINICIAN.

2. **PAYMENT**: We will file necessary claims to insurance companies in your name to obtain payment for services provided. They may request part or all of your medical record to pay the claim.

3. **HEALTH CARE OPTIONS**: Any other involved in your healthcare, for example financial or billing audits, defense or legal matters. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

I understand the above Notice of Privacy Practice: _____ **Date:** _____

APPOINTMENT REMINDERS

We may call you and leave a message to remind you of scheduled appointments. Unless you tell us otherwise, we mail you appointment every 12 months as a reminder

CANCELATIONS

Cancellations must be done with a 24 hour notice or a $25.00 dollar fee will be charged to the patient for missed or broken appointments

IDENTIFICATION

A copy of your insurance card and picture ID are required for all patients. We require a copy of all insurance cards and ask that you bring them with you and present them at the time of the visit.

When signing below, you acknowledge that you have read and understand the above information and that you had the opportunity to review a copy of the complete Central Florida Eyes Notice of Privacy Practices available at the front desk. Also you authorize the release of your health information to your insurance company only to obtain reimbursement for professional services provided.

_____ _____

Patient's Signature/Parent, Guardian or Legal Representative Date

_____ _____

Printed Name Relationship to Patient