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CONSENT OF TREATMENT, BILLING, AND NOTICE OF PRIVACY PRACTICES

I, the undersigned, authorize Ithaca Eye Care Optometry, PLLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third party payers and other health practitioners involved in my care. I authorize and request my insurance company to pay directly to Ithaca Eye Care Optometry, PLLC all insurance benefits otherwise payable to me for services rendered. I understand that my eye care or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to be responsible for payment of all services even if my insurance deems said services as a lack of medical necessity, experimental or investigational. Service charges of 1 1/2 % per month will be added to all balances over 60 days past due. In the event it becomes necessary to collect a balance through litigation or a collection agency, I agree to pay all collection fees, and attorney's fees incurred. I further authorize the use of this signature on all insurance submissions.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We are committed to maintaining the privacy of your protected health information ("PHI"). We are legally required to record information about your health condition and the care and treatment you receive here, and this record-keeping is critical to your safety. This Notice details how your PHI may be used and disclosed to third parties. It also reviews your rights regarding your PHI. Our records are electronic and can be accessed only by the doctor and staff via password entry. We do not send records by email without encrypting them to prevent their being read by parties other than the intended recipient. You have the right to see the records that we keep about your care.

The uses and disclosures of PHI for marketing purposes, disclosures that constitute a sale of PHI, as well as disclosures not described in this Notice require authorization from the patient. Patients have the right to opt out of receiving fundraising communications. Patients have the right to restrict certain disclosures of PHI to a health plan where the patient pays out-of-pocket in full for the health care item or service. Affected patients have the right to or will be notified following a breach of unsecured PHI.

We may disclose your PHI to other parties, without a separate consent for its release, in the following situations: 1) to other doctors and health care providers who are already treating you with your consent, or to whom you are being referred as part of our explicit plans (you will know when this is going to occur); 2) to third party payors (e.g. Medicare or your insurance company) in order for you to receive the coverage benefits that pay for your care; 3) to various third parties who are monitoring the quality of the care you receive, as required by law; and 4) to our business associates such as billing services.

The Practice may also disclose your PHI, without a written Consent from you, in the following additional instances: 1) Identified information that does not identify you and, even without your name, cannot be used to identify you; 2) To a business associate if we obtain satisfactory written assurance, that they will appropriately safeguard your PHI; 3) To a person who, under applicable law, has the authority to represent you in making decisions related to your health care; 4) for the purpose of obtaining or rendering emergency treatment; 5) To a government authority if the Practice is required by law to make such disclosure regarding physical abuse or neglect; 6) To agencies charged with Health Oversight Activities, as required by law, including criminal investigations; 7) In response to a court order or a lawfully issued subpoena; 8) to a law enforcement official under certain circumstances; 9) To a coroner or medical examiner for the purpose of identifying you or determining your cause of death; 10) To an entity to whom you have agreed to donate your organs; 11) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public (to an individual who is reasonably able to prevent or lessen the threat); 12) To the Workers' Compensation system; 13) To contact you with appointment reminders, treatment alternatives, and health related benefits and services.

X_____ X_____ Date _____
Signature of Patient or Parent **Printed Name of Patient or Parent**

Contact Lens Evaluation Fee

Our comprehensive exam includes a glaucoma test, dilation, and overall eye health evaluation; it does not include the evaluation of contact lenses. A patient currently wearing contact lenses, in which the doctor recommends the same type of lens, is required to have a contact lens evaluation annually in order to maintain a valid prescription. The contact lens prescription is determined by an evaluation of the lens, the eyes response to the lens and the visual acuity. Most insurance companies do not cover the contact lens portion of the eye exam. The cost for the Contact Lens Evaluation is $50. If a contact lens refit is necessary other fees may apply and will be discussed. By signing you are agreeing to the evaluation and know that the fee must be paid in full at the time of service.

X_____ X_____ Date _____
Signature of Patient or Parent **Printed Name of Patient or Parent**