Authorization for Release of Information

This form authorizes MacMillan Optical to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- ☐ Financial/Billing Information
- ☐ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

- ☐ Patient's voice mail/answering machine
- ☐ Voice mail/answering machine of (e.g. spouse, parent sibling):

_____ _____
Name/Relationship to patient Phone

_____ _____
Name/Relationship to patient Phone

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to MacMillan Optical. I understand that a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

X_____
Signature of Patient (parent or legal guardian if minor)

Notice of Privacy Practices

MacMillan Optical has provided me a copy of their Notice of Privacy Practices for my review upon check in.

X_____
(Please Initial)

Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to MacMillan Optical.

X_____ _____ _____
Signature of Patient (legal guardian if minor) Print Name Date

In keeping with our mission to provide the latest technology in caring for your eyesight, we offer an elective procedure-digital retinal imaging, the digital retinal camera takes and image of the optic nerve and retina (the camera film at the back of the eye). The images are added to your medical records assisting you doctor in the early detection of glaucoma, diabetic retinopathy, macular degeneration, retinal tears or detachments, and other vision threatening conditions.

For most patients the doctor's view of the retina is limited by the small pupil size. We recommend digital retinal imaging should the dilation not be possible for you today. Both digital retinal imaging and dilation are helpful, though only dilation is medically necessary for routine eye exams and therefore included in the cost of the exam.

The cost for this procedure is $30. This is an additional, out of pocket expense, and is not covered by vision or medical insurance. Because of known risk factors we strongly recommend the tests for the following:

Family history of Glaucoma	**Headaches**
Family history of Diabetes	**Spot or flashes of light**
Over the age of 40	**High Cholestrol**
Family history of high blood pressure	**New patient**

_____I elect to have this $30.00 procedure **_____I decline these additional services**