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Cascade EyeCare Center

Physicians & Surgeons • Ophthalmology

Douglas R. Merritt, M.D.
Rodney D. Leavitt, M.D.
Matthew R. Guymon, D.O.
Matthew D. Fullmer, D.O.

ACKNOWLEDGMENT AND CONSENT

I, _____ understand that Douglas R. Merritt M.D., Rodney D. Leavitt M.D., Matthew R. Guymon D.O., and Matthew D. Fullmer D.O., (referred to below as "This Practice") will use and disclose **health information** regarding my care (or that of a legal minor/guardian).

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- provide patient with their own medical record;
- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare; and
- perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **NOTICE OF PRIVACY PRACTICES** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests. I understand that in case of emergency I may call the office and the on-call doctor is available.

I understand I will be financially responsible for all services rendered, including, but not limited to, exams, special testing, and refraction (test to determine prescription for glasses). Insurance will be billed for services covered by your plan; however, I am responsible for any balance due after my insurance has been billed, including any co-pay, co-insurance, and payments toward my deductible if my deductible has not been met

I understand that this authorization is valid indefinitely unless revoked by patient. **By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices. I acknowledge that I have received a patient information packet outlining Cascade's policies and my responsibility as a patient.**

Signed _____ Date _____

☐ Patient ☐ Parent/Guardian ☐ Guarantor