Vision Source

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Our office is required by law to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices describing how your medical information may be used and disclosed.

By signing below, you acknowledge that:

- **You have been offered a copy of Vision Source's Notice of Privacy Practices.**
- **You understand that your health information may be used and disclosed for purposes of treatment, payment, and healthcare operations.**
- **You understand your rights regarding your protected health information, including the right to request restrictions, access your records, request amendments, and receive an accounting of certain disclosures.**
- **You understand that Vision Source reserves the right to update its Notice of Privacy Practices and that a current copy will be available upon request and on our website.**

Patient Information

Patient Name: _____

Date of Birth: _____

Acknowledgment (HIPAA long form is available by request)

I acknowledge that I have received, been offered, or have had the opportunity to review Vision Source's Notice of Privacy Practices.

Patient Signature: _____X Date:

Policies

As part of our commitment to comprehensive eye care, Vision Source incorporates Optomap® digital retinal imaging into Low Vision evaluations. This advanced technology enables the doctor to thoroughly assess the health of the retina (the back of the eye) and better understand how disease may be impacting your vision.

The Optomap® imaging and Low Vision evaluation will be billed to your medical insurance and may incur a medical copay or deductible. If you have a vision plan, any available benefits may be applied to your purchase of eyewear.

If you need to cancel or reschedule an appointment, we request 48 hours' notice. Patients who fail to provide adequate notice or miss their appointment may be required to pay a $75.00 rebooking fee before scheduling a future appointment. Appointments are reserved for one hour, so we appreciate a timely notice to offer the slot to another patient.

Insurance plans typically do not cover the cost of low vision devices; however, HSA, FSA, and senior benefit cards may be used. Please bring your card with you to your appointment.

Patient Signature: _____X Date_____

VISION SOURCE COMMUNICATION AUTHORIZATION

Patient Name: _____DOB_____

I understand that Vision Source may need to contact me regarding:

- **Appointments**
- **Treatment recommendations**
- **Test results**
- **Billing matters**
- **Eyewear and contact lens orders**
- **Account balances**
- **Other healthcare-related information**

I authorize Vision Source to communicate with me using the following methods:

COMMUNICATION PREFERENCES

X TEXT MESSAGE I authorize Vision Source to send appointment reminders, recall notices, billing notifications, and other healthcare-related communications via text message.

X EMAIL I authorize Vision Source to send appointment reminders, billing information, educational materials, and other Healthcare-related communications via email.

X VOICEMAIL I authorize Vision Source to leave detailed messages regarding appointments, test results, treatment plans, billing matters, and other healthcare-related information on my voicemail.

PatientSignature:_____X Date:

VISION SOURCE

PROTECTED HEALTH INFORMATION

I understand that email and text messaging may not always be secure forms of communication.

By signing below, I acknowledge and accept any associated risks and authorize Vision Source to communicate with me using the methods selected above.

PERSONAL REPRESENTATIVE AUTHORIZATION (OPTIONAL)

I authorize Vision Source to discuss my medical information, appointments, and billing information with the following person(s):

Name: _____

Name: _____

***If applicable, I authorize Vision Source to communicate with Lions Club, Memorial Foundation for the Blind, Massachusetts Commission for the blind, Esight, and Massachusetts Association for the blind**

PATIENT ACKNOWLEDGMENT

PatientSignature:_____X Date:

Vision Source of Worcester 335 Park Ave Worcester, MA 01610

(508) 753-5103