Emory Eyecare
886 E. Lennon Dr. Ste. 102
Emory, Texas 75440
Phone: 903-473-2020

PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Patient DOB: _____

Initials

_____ **AUTHORIZATION FOR CARE**

I grant permission for ELK Vision Holdings, LLC - Emory Eyecare to render such care that my provider may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment, digital imagery, diagnostic testing and minor surgical procedures.

_____ **AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize ELK Vision Holdings, LLC - Emory Eyecare to release necessary information for the following reasons: to other providers for continuing professional care; to any insurance company or third-party payer for the purpose of processing a claim; to be contacted regarding care or otherwise as allowed by law. I release Emory Eyecare from any liability for the release of this information.

_____ **HIPPA NOTICE OF PRIVACY PRACTICES**

ELK Vision Holdings, LLC - Emory Eyecare is required by applicable federal and state law to maintain the privacy of your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that release to your past, present or future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. By initialing this box, you acknowledge that you have been given or offered the "Notice of Privacy Practices" of ELK Vision Holdings LLC – Emory Eyecare.

_____ **SECURE MESSAGING AND ELECTRONIC COMMUNICATION**

ELK Vision Holdings, LLC – Emory Eyecare has the ability to correspond with patients and providers electronically through a secure messaging portal. I hereby authorize ELK Vision Holdings, LLC – Emory Eyecare to electronically communicate via email and/or text message, when applicable regarding my healthcare.

Patient or Legal Guardian **EMAIL** for secure electronic communication: _____

HIPAA ACCESS FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of ELK Vision Holdings, LLC - Emory Eyecare is to restrict access to my Protected Health Information. In addition to other providers providing health services, and my insurance company(-ies) for payment of my claim, I would like for the following person(s) to have access to my Private Health Information:

Printed Name:	Phone Number:	Printed Name:	Phone Number:
_____	_____	_____	_____

Patient or Legal Guardian Signature: Date:

_____ _____

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RETINAL PHOTOGRAPHY

Patient Name: _____ Patient DOB: _____

Retinal photography is a non-invasive procedure used for the early recognition of retinal problems such as those related to **glaucoma, macular degeneration, diabetes, high blood pressure or cholesterol.**

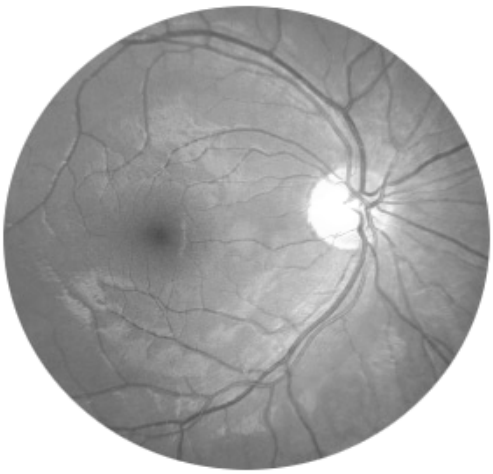
Your provider uses digital photography as a screening to document retinal conditions and **provide exceptional baseline data** that can be used to monitor the progression of your ocular health.

Your provider recommends the screening retinal image with every complete eye examination. You will view the images with your provider and **results will be discussed** fully during your exam.

Screening images are not required by medical necessity; they are **optional**. There is an ***additional*** charge of **$15.00** for this procedure.

_____ YES, I would like to have screening retinal photography.

_____ NO, I would not like to have screening retinal photography.



Patient or Legal Guardian Signature: Date:

_____ _____