



## Summary of Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at (573) 874-2030

We have summarized the Notice of Privacy Practices by providing you with the following. If you wish to have a more detailed description of your rights and our responsibilities, please ask.

### Your Rights

Your rights related to your medical information are as follows:

- The right to request restrictions on the way we use your medical information;
- The right to request and receive information from us in a different way or manner;
- The right to review your medical information;
- The right to request that we amend your medical information; and
- The right to know how we have used or disclosed your medical information.

We will not use or disclose your health information without your authorization, except to obtain **payment for treatment** (such as sending billing information to your insurance company or Medicare), **treatment** (such as sending medical information about you to a specialist, your family doctor or other health care facility as part of a referral) or to support our **health care operations** (such as comparing patient data to improve treatment methods or to business associates for the purpose of helping us to comply with our legal requirements).

### What We Are Required To Do

It is our responsibility to:

- Protect you medical information;
- Provide you with our Notice of Privacy Practices; and
- Abide by the terms of this Notice.

We can change our privacy practices. If we decide to change them, we will change this Notice and post the changes in our office.

We are providers for Medicare, Missouri Medicaid, Blue Cross / Blue Shield, Blue Choice, Vision Care Direct, Mercy Healthcare and Healthlink. If you have other insurance, we will provide you with an itemized receipt on the day of your examination which you may file with your insurance company. If you do not have one of the plans we accept, payment is requested on the day services are rendered.

Insurance Carrier: \_\_\_\_\_

I have read and understand the above information and I agree to pay for any services and materials which are not covered by my insurance. I acknowledge that I have received the Notice of Privacy Practices from Columbia Eye Consultants Optometry.

Patient's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_