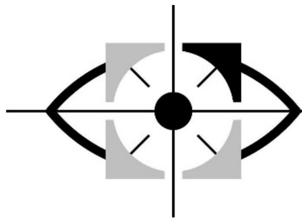

Northeast Wisconsin Vision Center, Ltd.

Stephen J. Merfeld, M.D.
Eric M. Larson, M.D.
Paul H. Payant, O.D.
1885 West Pointe Drive
Oshkosh, WI 54902
(920) 232-6550

HIPAA PATIENT CONSENT FORM

Northeast Wisconsin Vision Center, Ltd. provides this consent to comply with the privacy regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of (1996) HIPAA.

We understand that your medical information is personal to you and we are committed to protecting such information. As our patient, we create medical records about your health, our care for you and the services and/or items we provide you. By law, we are required to make sure that your protected health information is kept private.
This is a summary of and consent for the privacy practices and patient care at Northeast Wisconsin Vision Center and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent. The terms of our Notice may change and you may obtain a revised copy by contacting our office.
If you ever believe your privacy rights have been violated, you may file a complaint with the compliance officer of Northeast Wisconsin Vision Center or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filling complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULL.

How will we use or disclose your information? Here are a few examples:

- For vision, medical eye treatment, and referral
- To obtain payment and file insurance claims
- In emergency situations
- For appointment and patient recall reminders
- To prevent serious threats to health safety
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include: the right to inspect and copy; the right to amend; the right to an accounting of disclosures; the right to request restrictions; the right to a paper copy of this notice; the right to request confidential communications.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Northeast Wisconsin Vision Center may condition treatment upon the execution of this consent.

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Northeast Wisconsin Vision Center providers and their respective employees to use or disclose my personal health information during the term of this consent to the follow recipient(s):

Name(s):

Term: I understand that this consent will remain in effect for one calendar year from the date signed.
Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this consent or be applicable to federal or state laws governing the use and disclosure of my PHI.

Signature:____ Date: ______________________

Insurance Authorization and Assignment of Benefits
I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Northeast Wisconsin Vision Center, LTD. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature:____ Date: ______________________

Medicare Patients
If you are covered by Medicare, please read and sign the following:
In Medicare cases, Northeast Wisconsin Vision Center, LTS, agrees to accept the charge determination of Medicare as the full charge, and the patient is only responsible for deductible, coinsurance, and non covered services. Coinsurance and deductibles are based upon the charge determination of Medicare.

Signature:____ Date: ______________________