Optic Gallery

Patient Privacy Notice Summary:

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you. The protection of your privacy is a key part of maintaining your trust. This has been a fundamental operating principle of Optic Gallery Downtown Summerlin since our founding and remains so today. This patient privacy notice summary lets you know we maintain strict internal policies regarding confidentiality of patient information (PPI) we maintain physical, electronic and procedural safeguards that comply with federal guidelines to safeguard patient information. Our employees are bound by our policies to access patient information only for legitimate clinical and/or business purposes and to keep such information confidential at all times. We pledge to do all we can to protect your privacy. If you have any questions about our privacy policy, or about how our information is maintained, safeguarded or used please contact our privacy officer, Trudie Lee at (702) 938-2020. Signing this section signifies that you have read and received a copy of our Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date ____/____/____

Medical Services Contract:

I hereby authorize and consent to medical treatment by Optic Gallery Downtown Summerlin for me (or my child). I authorize Optic Gallery Downtown Summerlin to release my (or my Dependant's) medical records to our family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Optic Gallery Downtown Summerlin or other authorized parties. I understand that I am responsible for payment of all vision and medical treatment rendered to me by Optic Gallery and I agree to pay all co-payments, deductibles, and non-covered services at the time of visit. I understand that, as a courtesy to me, Optic Gallery Downtown Summerlin will file a claim with my insurance carrier and I authorize payment directly to Optic Gallery Downtown Summerlin for the benefits otherwise payable to me under the terms of my insurance coverage. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier.

Signature of Patient/Guardian _____ Date ____/____/____

Consent for Dilation of the Eyes

In order to perform a thorough and complete ocular exam, it will be necessary for us to dilate your pupils. Dilation allows the doctors at Optic Gallery Downtown Summerlin to obtain a better view of the back of the eye. Many medications, vitamins, and foods can influence the health of your eyes and vision. Diseases such as High Blood Pressure, Diabetes, Arthritis, Auto-immune disorders and many other conditions can affect our ocular health and vision. Dilation specifically allows us to examine the Optic Nerve, Blood Vessels, Macula and extreme edges of the retina to ensure that no problems exist that could potentially lead to permanent vision loss. Side effects of dilation include blurry near vision for approximately 4-6 hours, and light sensitivity. Our Doctors strongly recommend caution when driving or operating equipment or machinery after dilation. Signing below signifies you have been informed of the risks and benefits of dilation, please select one of the options below:

- I wish to have my eyes dilated today _____
- I do not wish to have my eyes dilated and I assume the responsibility of having an eye exam without dilation _____
- I wish to discuss dilation with the doctor before making a decision _____

Signature of Patient/Guardian _____ Date ____/____/____