Link Eye Center/Matthew J. Link, O.D. LLC
245 Bloomfield Drive, Suite 108, Lititz PA 17543

Notice of Privacy Practices

I consent to the use and disclosure of any information concerning my optometric examination as needed to:

- Conduct, plan or direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance or other payers.
- Conduct normal healthcare operations such as recalls and appointment confirmations.

I have read and understand or have been given the opportunity to read your **Notice of Privacy Practices** containing a more complete description of other uses and disclosures of my health information. I understand that your office has the right to change its Notice of Privacy Practices from time to time and that I may request a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Responsibility for Payment

If your office agrees to third party reimbursement for services rendered, I authorize you to submit a vision and/or health benefit claim on my behalf. I understand that I am responsible for all charges incurred, including any portion not paid by any other payer, subject to the conditions of any contractual agreement between your office and such payer.

I acknowledge that I have read and understand or have been given the opportunity to read your **Financial Policy** and that I may request a copy at any time.

Our office does not partner with Medicaid. If you choose to receive care here, you will be responsible for the full cost of all materials and services.

Please note, we would appreciate 24 hours given if you must cancel your appointment or a “no show” fee may be applied.

Name: _____Date: _____

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Communication Preferences

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy. We will only use standard email for general correspondence, financial statements, contact lens, and eyeglass prescriptions. We do not send medical records by standard email. However, our correspondence by text is secure, and we can send you text to pay options.

___ I authorize the use of standard email.

Email address:_____

___ I do not authorize the use of standard email.

___ I authorize the use of texting.

Cell phone: _____

___ I do not authorize the use of texting.

HIPPA Preferences

In addition to my primary care physician, my insurance company, and the responsible party listed on my patient history, I authorize you to release necessary information to (please list other physicians, family members, opticians, etc.) We can only release materials or records the individuals listed below.

Name: _____Relationship: _____Contact Info: _____

Name: _____Relationship: _____Contact Info: _____

Name: _____Relationship: _____Contact Info: _____

Name: _____Relationship: _____Contact Info: _____

Patient Signature

Printed Name: _____Signature of Patient: _____ Date: _____

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