CATRACT & LASER INSTITUTE OF PA

PATIENT WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby acknowledge receipt of the CATARACT & LASER INSTITUTE OF PA's **Notice of Privacy Practices.**

Name [please print]: _____

Signature: _____

Date: _____

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby authorize the practice to **use an automated appointment reminder system** for contacting me. The practice may use any telephone numbers provided by me including, but not limited to ***home and cell numbers.***

Name [please print]: _____

Signature: _____

Date: _____

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby acknowledge, authorize and **Consent to All Examination and Treatment** necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physicians, doctors of optometry and clinicians of the Cataract & Laser Institute of PA including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of all my records, if necessary.

Name [please print]: _____

Signature: _____

Date: _____

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Cataract & Laser Institute of PA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____	_____ yes	_____ no
Parent: _____	_____ yes	_____ no
Other: _____	_____ yes	_____ no
_____	_____ yes	_____ no
_____	_____ yes	_____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME _____

Patient/Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____