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Patient Acknowledgement of Receipt of Notice of Privacy Practices and Rights and Responsibilities

Initials

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices and Patient Rights and Responsibilities before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from the Privacy Office, Clinical Resource Management, The Eye Surgery and Laser Center, LLC, Baptist Drive, Suite 200, Madison, Mississippi 39110.

By signing this form, you acknowledge that you have been provided a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities. You are also signing this form acknowledging that you have reviewed both forms and have no further questions regarding these forms.

Assignment of Benefits and Release of Information

Initials

I request the assignment of Medicare, Medicaid or my private health insurance benefits be made to Eye Surgery and Laser Center, LLC for any services furnished me. I authorize the release of any medical information necessary to process these claims.

Responsibility for Payment and Communications

Initials

I understand that I, the patient or patient representative, am responsible for payment of charges and for services rendered. Past due accounts and returned checks will be subject to collection charges, penalties, and interest. I give my consent to receive communications from servicers and collectors of my accounts, through 1) cell, landline, or text numbers that I provide, 2) email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Breach of Security Statement

Initials

In the event of a security breach that requires my notification, I authorize you to contact me by the email address I provided you. I understand that:

- If I do not have access to email, that I will be informed by phone or mail
- That I am responsible for giving any updates of my email address; and that The Eye Surgery & Laser Center, LLC will not be held responsible if they are unable to contact me if I have not done so.

Fee for Release of Medical Records

Initials

I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

Grievance Filing Contact Information:
Center: Ambulatory Surgical Center Director
601-985-9120

Mississippi State Department of Health
1-800-633-4227

AAHC: Accreditation Association for Ambulatory Healthcare
1-847-853-6060

Patient Signature _____

Date _____

Witness Signature _____