Dr. Thomas Suzuki
53 Aspen Way. Watsonville, CA 95076
831-724-1097

Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____

Patient Address: _____

Patient Home Number: _____ Patient Cell Number: _____

Patient Work Number: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for our services and to conduct health care operation involving our office.

The **Notice of Privacy Practices** you have been given describes the uses and disclosures in detail. You are free to refer to this notice at anytime before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provide here, but also discloses you health information as may be necessary or appropriate to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insures for claims review, determination of benefits and payment; (3) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for the purpose of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices** we are not obligated to agree to the suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from: The Offices of Thomas Suzuki O.D.

O Check if a COPY of privacy practices has been declined.

_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship and the source of authority to sign this form.

_____ _____

Relationship to Patient Print Name