Consent
The Eye Specialists of Atchison, LLC

The office of Andrea Bock-Kunz, MD, and Sara Petska, OD; ***must obtain your consent to enable us to provide treatment, bill insurance, and to supply insurance companies any additional information needed to approve payment of treatment received in our office. This is protected health information that our office strives to keep confidential***

You may revoke this consent at any time by notifying our office.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that office/staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

This office has reserved the right to change its privacy practices described in its Privacy Notice. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. (This office is not required, however, to agree to such requested restrictions. If, however, our office agrees to the requested restriction, we will honor the request and it will be binding.)

MEDICARE NOTICE: Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (A) (1) of the Medicare Law. If Medicare determines that a particular service is 'routine' or is not 'reasonable and necessary' under Medicare program standards, Medicare will deny payment for service. ***The refraction portion of your exam that determines the needed prescription in your glasses is considered routine eye care and will not be covered by Medicare.***

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I hereby consent to the use and disclosure of this office and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

______________________	______________________
Signature	Signature of Personal Representative of Patient
______________________	______________________
Date	Description of Representative's Authority to Act For Patient