REQUEST FOR ELECTRONIC COMMUNICATIONS

Name of Patient(s): _____
Date(s) of Birth_____

Email address: _____@_____ (please print clearly)

Cell #_____

____ I authorize Beaverton Eye Health to send me documentation (such as copies of my prescriptions, receipts, and/or exam reports) electronically.
____ **DO NOT** send documentation to me electronically. I will pick documents up in-person or request they be mailed to my postal mailing address

All Records are renewed every **3 years**

Acknowledgement and Agreements: I understand and agree that the requested communication method is not secure, making my PHI (Protected Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

SIGNED: _____ Date: _____

Personal Representative: _____
(only if patient is unable to complete forms, i.e., minor child, patient needing translation, or disabled patient with caregiver or Power of Attorney)

HIPAA ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Signature: _____

Date: _____

APPOINTMENT CANCELLATION POLICY

Appointments canceled within 48 hours prior to appointment time, you will be charged a $50 cancellation fee.

If you arrive more than 10 minutes late to your appointment, we will need to reschedule you for another time and you will be charged a fee of $50. Out of respect and consideration to our clinic and other patients, please plan accordingly and be on time.

Patient Name: _____ Signature: _____

Date: _____

OFFICE USE ONLY
Request Received by: _____ Date Received: _____