

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (HIPAA)**

The law requires that Amanda Misinco PLLC, dba Optical Intuitions, make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I was given the opportunity to read, have read or had explained to me Amanda Misinco PLLC's Notice of Privacy Practice prior to any services offered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

Current HIPAA laws require your written authorization to release your personal health information to a person other than yourself. Understand that your information may need to be discussed with your current physician or referred to/from specialists in regards to scheduling of procedures, consultations, and health history that may impact your vision and eye health. Only the information needed to do this will be released.

**Who may we release your personal health information to?** (e.g. spouse or other family member)

\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_  
Name Relationship to Patient

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

\_\_\_ I authorize the use of text and email.

\_\_\_ I do not authorize the use of text and email to communicate with me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CANCELLATION AND MISSED APPOINTMENT POLICY**

In order to be respectful of the needs of all our patients, please call Optical Intuitions promptly if you are unable to make your reserved appointment time. If it is necessary to cancel your scheduled appointment, we request that you call at least 24 hours in advance. Your early cancellation will give another patient the opportunity to receive care. We understand that unavoidable circumstances may warrant special consideration, but please note a \$25 charge may be applied to your account if your missed appointment is not cancelled with at least 24-hour advance notice. Thank you for your cooperation as we strive to best serve the needs of all our patients.

**May we leave a message on your voicemail or text you to confirm future appointments?**

Yes No

Signature \_\_\_\_\_ Date \_\_\_\_\_