NJ Eye & Ear PEDIATRICS
Formerly Clifton Eye Care Pediatrics

HIPPA: PATIENT RIGHTS AND RESPONSIBILITIES

It is the policy of NJ Eye and Ear to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. We make every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. We will do everything we can to see that your experience with us is professional in every way.

NJ Eye and Ear is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask. By signing this form, I agree that NJ Eye and Ear may send automated text messages to my cell phone for appointment reminders, news and promotional information. I understand that standard text messaging rates will apply to any message received from NJ Eye and Ear. I understand that I may revoke this permission at any time by notifying NJ Eye and Ear in writing.

Patient Rights:

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

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Patient Responsibilities:

1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
4. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: **Protected Health Information may be disclosed or used for treatment, payment of health care operations. The Practice has a notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Policies. The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The Patient may revoke this Consent in writing at any time and all future disclosures will then cease. The practice may condition treatment upon the execution of this Consent.**

Patient Name: _____ Date of Birth:_____

Patient/Guardian Signature: _____

Relationship to Patient: _____

Email:_____ _____ Social Security #:_____

Pharmacy Name: _____ Phone: _____

Emergency Contact:_____ Phone: _____

Witnessed by: _____ Todays Date: _____

Rev: 1/2/2018