

ADVANCED EYE CARE
Notice of Privacy Practices

As our Patient, we are offering you a copy of Advanced Eye Care's
Notice of Privacy Practices to retain for your information/reference.

Copies are also available at any time from our office. You are welcome to
review or have a copy of this notice at any time upon your request.

COMPLAINTS/COMMENTS

If you have any comments, questions, or complaints concerning our privacy practices, you may also contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (email: ocrmail@hhs.gov)

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR
MAKING AN INQUIRY OR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact:

Dr David Millikan O.D.
Advanced Eye Care
14555 Hazel Dell Pkwy
Carmel, IN 46033
Attn: Patient Privacy Request

SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of the Advanced Eye Care Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you as well. A copy of this signature page will be maintained in your records and can also be given to you upon request.

Patient Signature

Date

Patient Name - [Printed]

Advanced Eye Care

14555 Hazel Dell Pkwy

Carmel, IN 46033

317-844-EYES (3937)

A Statement to Advanced Eye Care Patients Regarding Dilation of Your Eyes

We would like to inform our patients that it may be necessary during the course of your exam to **dilate your eyes with drops**. In some people, the dilating drops cause blurred vision, light sensitivity, and inability to read. These problems go away as the effects of the drops wear off. You should be careful walking, going up and down stairs, and should be extremely cautious if it is necessary for you to drive. In very rare cases, the drops may cause elevated eye pressure requiring further treatment.

It is for these reasons that we recommend someone come with you at the time of your exam as a driver. If the patient is a child that will be returning to school, we recommend that their teachers are informed that they have had a dilated eye exam. Also, for your comfort, we suggest bringing a pair of sunglasses to wear after your appointment.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye examination.

Signature of Patient /

Parent or Guardian: _____

Date: _____