elevate
VISION THERAPY & REHABILITATION

Patient's Name:
Preferred Name:
Date of Birth:

Address:

Phone Number:
Email Address:

Often, the doctors and their staff will communicate with patients by email to get information to you more efficiently. Signing below allows us to exchange information via email when necessary.
Please initial if you are comfortable with receiving correspondence regarding your appointments and vision care by email: _____

Please indicate others we are permitted to share medical, scheduling and billing information with:

How did you hear about us?

Please list any providers you would like us to send a visit summary to:

Please authorize us to release your medical information to the providers listed above by initialing here: _____

Please list any medications you are currently taking:

Please list any allergies you have to medications:

Please list any medical conditions you are diagnosed with:

When was your last eye examination with an optometrist/ophthalmologist? Do you currently wear glasses or contact lenses?

Today's examination with the doctor will not include an evaluation of ocular health. Having one's ocular health evaluated at a yearly eye examination is important. You are welcome to coordinate that visit with your current optometrist.

Please initial indicating that you have, or will, schedule an appointment for an ocular health evaluation: _____

Have you ever had a concussion or stroke? If so, what was the date of your most recent concussion or stroke?

Do you experience any of the following:	**Yes**	**No**
Blurred vision?	____	____
Double vision?	____	____
Headaches or eye strain?	____	____
Skipping/repeating words/lines when reading?	____	____
Dizziness or nausea?	____	____
Poor eye/hand coordination?	____	____
Light sensitivity?	____	____
Difficulty with short-term memory?	____	____

Financial Responsibility:

Your signature below signifies that you clearly understand that Elevate Vision Therapy & Rehabilitation is NOT a member of your insurance plan.

Because the doctor is not on your plan, the expenses for today's visit will be your responsibility. The estimated cost of today's visit is $240. This means you will have to pay the doctor's charges in full at today's visit.

Our office will not file a claim to your carrier. Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is not part of the

plan or network. Do NOT sign this form unless you completely understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating physician today.

I understand and agree to the above Financial Responsibility Policy:

Guardian/Patient Signature:

Date:

Privacy Information:

The law requires that Clark Optometric Vision Therapy (dba Elevate Vision Therapy & Rehabilitation) 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 Clark Optometric Vision Therapy's Notice of Privacy Practice prior to any services offered. I have read and understand this form and am signing it voluntarily.

Guardian/Patient Signature:

Date:

Effective Date of Notice: 04/01/2026

Notice Of Privacy Practices

Clark Optometric Vision Therapy, Inc, d/b/a Elevate Vision Therapy & Rehabilitation
1398 Kildiare Farm Road, Cary, NC 27511
833-882-8886
Fax: 888-400-4210

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, testing or examining your eyes, prescribing glasses and faxing or calling them to be filled, providing vision therapy sessions, getting copies of your health information from another professional that you may have seen before us, and sending information to referring providers after you have seen us. Examples of how we use or disclose your health information for payment purposes are: asking about sources of payment, preparing superbills, and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions, defense of legal matters, business planning, and outside storage of our records.

We routinely use your health information inside our office for these purposes. If we need to disclose your health information outside of our office for these reasons, we will ask you for special permission.

USE AND DISCLOSURES FOR OTHER REASON WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notice to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral director to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses or disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized governmental functions, such as for the protection of the resident or high ranking officials; for lawful national
- intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations; Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to 'business associates' who perform health care operations for us and who commit to respect the privacy of your health information.
- Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments. We may also call or write to notify you of other treatments or services available at our office that might help you. It may be necessary to leave a reminder message on your answering machine, voicemail, or with someone who answers your phone.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosure of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing and must be sent or brought to the office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosure for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor restrictions that you want. To ask for a restriction, send a written request to the office. Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office.

Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have an electronic copy of your health information within 30 days of asking us (or sixty if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instruction about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access to photocopies if we send you a written notice of the extension. If you want to preview or get photocopies of your health information, send a written request to the office.

Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with our health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office.

Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for the purpose of treatment, payment or health care operations; disclosure with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office.

Get additional paper copies of this Notice of Privacy Practice upon request. It does not matter whether you got one electronically or paper form already. If you want additional paper copies, send a written request to the office.

OUR NOTICE OF PRIVACY PRACTICE

By law, we must abide by the terms of this Privacy Practice until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think we have not properly respected the privacy information, you are free to complain to our Privacy Officer (Michael Marino, OD), and office General Manager, or the US Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office.

This privacy statement represents the policies of the owners, the contracted doctors, and all the staff of Clark Optometric Vision Therapy, Inc, d/b/a Elevate Vision Therapy & Rehabilitation.