Dr. BRYAN C. FRIEDMANN, OPTOMETRIST
201-1581 Hillside Ave, Victoria, BC, V8T 2C1, (250) 595-1157, info@drfriedmann.ca

CONSENT FOR PERSONAL INFORMATION

NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we will provide to you and what we do with personal information we obtain about you.

CONSENT

I understand that, to provide me with optometric services and products, this practice will collect some personal information about me (e.g. phone number, address, email, birth date, BC Services Number, medication, etc.). This office will provide this information when necessary to a medical doctor or ophthalmologist as pertaining to my treatment.

I have reviewed this practice's Privacy Policy (available upon request) with respect to the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy and they have been answered to my satisfaction.

I understand that I may receive a notice via telephone, email, text, or mail of when it is time to review my eye and vision care needs, including reminder notices for another eye exam. If I do not want to receive any reminder notices, I agree to advise the practice of my refusal in writing. I also understand that, as explained in the Privacy Policy, there are some rare exceptions to these commitments.

I agree to this practice collecting, using, and disclosing personal information about me as set out above and in this practice's Privacy Policy.

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS TO OPTED OUT PRACTITIONER

I authorize the Medical Service Plan of British Columbia to pay Dr. Bryan Friedmann, Practitioner number 88080 directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by the said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Service Plan, which will be directed to Dr. Bryan Friedmann.

Name of Patient: _____PHN of Patient _____

Signature of Patient: _____Date_____