Notice of Privacy Practices
Effective September 5, 2013

TotalEyeCare

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. If you have any questions please contact our office. We are required by law to; maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration. ***Other Uses***. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or

domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.
Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, **www.TotalEyeCare.com**. To obtain a paper copy of this notice please request it in writing.
Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.
Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office.
COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

I acknowledge having been provided this Notice of Privacy Practices.

Signed: _____ Date: _____

Medical History Questionnaire

Name:_____ Date of Birth:_____ Today's Date:_____

Please assist us in providing you with the most up to date eye care available by telling us a little about your health history.

What brings you in to see us today? (circle all that apply)

Eye exam **Laser Vision Correction** **New glasses** **New contacts** Other:_____

When was your last eye exam?_____ Name of the Eye Doctor_____

Are you currently wearing contact lenses? **Yes / No** Have you ever worn contact lenses? **Yes / No**

Have you noticed any changes in your vision with your correction on? Y / N
If yes, do you notice it more in your distance vision, near vision, or both? Distance / Near

When was your last physical_____ What is your family doctor's name_____

How many hours per day, on average, do you use a computer? _____

Do you smoke?_____ If no, have you ever smoked? _____

Patient's Medical History

Please **circle yes (Y)** below if you currently have any of the following or **no (N)** if you have not.

CONSTITUTIONAL
Y N Fever, Weight Loss/Gain

EARS/NOSE/MOUTH/THROAT
Y N Sinus Congestion
Y N Dry Throat/mouth

CARDIOVASCULAR
Y N Heart pain
Y N High Blood Pressure
Y N Vascular Disease
Y N Heart Surgery

RESPIRATORY
Y N Asthma
Y N Chronic Bronchitis
Y N Emphysema

GENITOURINARY
Y N Dialysis, kidney failure

GASTROINTESTINAL
Y N Diarrhea
Y N Constipation

MUSCULOSKELETAL
Y N Rheumatoid Arthritis
Y N Muscle pain
Y N Joint Pain

INTEGUMENTARY (SKIN)
Y N Eczema, skin cancer

NEUROLOGICAL
Y N Headaches
Y N Migraines
Y N Seizures

PSYCHIATRIC
Y N Depression, Anxiety

ENDOCRINE
Y N Diabetes
Y N Hyper/Hypo Thyroid

HEMATOLOGIC / LYMPHATIC
Y N Anemia
Y N Bleeding problems

ALLERGIC / IMMUNOLOGIC
Y N Lupus
Y N Allergies / Hay Fever

EYES
Y N Glaucoma
Y N Cataracts
Y N Diabetic Retinopathy
Y N Macular Degeneration
Y N Retinal Detachment
Y N Retinal Disease
Y N Eye/head injury

Y N Blindness
Y N Strabismus
Y N Lazy eye / Crossed eyes
Y N Amblyopia
Y N Blurry Vision with correction
Y N Tired eyes
Y N Decreased vision
Y N Dryness
Y N Burning
Y N Itching
Y N Double vision
Y N Eye pain
Y N Floaters or Light flashes
Y N History of eye surgeries

Family Medical History

Please **circle yes (Y)** below if anyone in your family has a history of any of the following or **no (N)** if they do not.

Y N Glaucoma If yes, please list their relation to you_____.
Y N Cataracts If yes, please list their relation to you_____.
Y N Diabetes If yes, please list their relation to you_____.
Y N Macular degeneration If yes, please list their relation to you_____.
Y N Retinal disease If yes, please list their relation to you_____.
Y N Blindness If yes, please list their relation to you_____.
Y N Crossed eyes If yes, please list their relation to you_____.
Y N Thyroid disease If yes, please list their relation to you_____.
Y N Heart disease If yes, please list their relation to you_____.
Y N High blood pressure If yes, please list their relation to you_____.
Y N Arthritis If yes, please list their relation to you_____.

Are you taking any medications (including eye drops)? **Yes / No** If so please list the name and purpose of the medication.

Do you have any allergies to medications? **Yes / No** If so please list them;

Is there any information on this questionnaire that was not addressed that you would like the Doctor to be aware of? If so, please list it here.

Thank you for assisting us in taking better care of your needs.

Welcome to

Total Eye Care

PATIENT INFORMATION

Name (Dr. / Mr./ Mrs./ Ms.)_____ Date of Birth_____

Mailing Address _____City_____ State____ Zip _____

Home #_____ Work #_____ Cell #_____

Social Security Number_____

Race: ___White ___ Hispanic ___ Black or African American ___ American Indian ___ Asian ___ Other _____

Ethnicity: ____ Not Hispanic or Latino ____ Hispanic or Latino

Occupation_____Employer/School_____

E-mail Address_____

In order to provide you with better service we are asking all Patients for an e-mail address for purposes of appointment confirmations, notification of contact and glasses deliveries, quarterly newsletters, product recall alerts and patient satisfaction surveys. ***We will never sell your e-mail address or allow a third party to use it.***

How did you hear about our office? _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I am the patient or the responsible party of the patient and have received a copy of Total Eye Care's Notice of Privacy Practices.

Signature_____ Date_____

RESPONSIBLE PARTY INFORMATION

(For patients under 18 years of age)

Name _____ Relationship to Patient_____

Date of Birth_____ Social Security Number_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home #_____ Work #_____ Cell #_____

Occupation_____Employer/School_____

E-mail Address_____

FINANCIAL RESPONSIBILITY STATEMENT

I agree to be responsible for all fees incurred for services and/or materials provided (including reasonable collection fees) regardless of insurance coverage.

Signature_____ Date_____

Insurance Responsibility Statement

We will be happy to file your vision and/or medical insurance claims as designated by your insurance company. We are happy to provide this service without any additional charge to you. We will do all that we can to help you receive the maximum benefits.

We go to great lengths to verify the amount and type of coverage you are allowed under your plan. We can quote your estimated coverage; however, final determination of your benefits will not occur until the insurance company receives your claim. In the event the insurance company determines that you are not eligible at the time of service, makes a determination that you are eligible for reduced level of coverage, or applies the charges to your deductible, by signing this statement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the insurance company.

Print Patients Name _____

Signature_____ Date_____

VISION INSURANCE INFORMATION

Member Name_____ Relationship to Patient_____

Member Date of Birth_____ Member SS Number_____

Member Employer_____ Phone Number_____

Insurance Company_____ Benefits Phone #_____

ID Number_____ Group #_____ Group Name_____

Claims Address_____ City_____ State_____ Zip Code_____

MEDICAL INSURANCE INFORMATION

Member Name_____ Relationship to Patient_____

Member Date of Birth_____ Member SS Number_____

Member Employer_____ Phone Number_____

Insurance Company_____ Benefits Phone #_____

ID Number_____ Group #_____ Group Name_____

Claims Address_____ City_____ State_____ Zip Code_____

Please return this form to the receptionist with your insurance cards.