PRACTICE POLICIES

Welcome to our office! *We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to providing the highest quality eye health care and service to our patients. We take great pride in each staff member's training and capabilities. So we all can enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies. If you have any questions, please do not hesitate to direct your questions to our Office Manager who will be most happy to address your concerns.*

Thank you, and once again, welcome!

REGULAR VISITS

Regular and follow-up preventive care is very important in maintaining long lasting eye health. Therefore, we encourage our patients to adhere to the recommended visits. We will advise you when it is time for your next visit and help you with appointments that best suit you and your busy schedule.

PAYMENT FOR SERVICES

Professional services are nonrefundable, and payment is due at time of service. We accept cash, Mastercard, Visa, Discover, American Express, Care Credit and personal checks. Bounced checks incur a $30.00 fee. Payment is due upon receipt and delinquent on the 15th day. Past due invoices may be sent to a collections agency. Patient agrees to pay all costs related to the collection of all sums including but not limited to legal fees and expenses.

APPOINTMENTS AND LATE CANCELLATIONS

Because we recognize that your time is valuable and we strive to minimize patient waiting time, we see our patients on an appointment basis (with the exception of emergencies – we will always squeeze in someone with a true medical emergency). If you are not able to keep an appointment, please phone our office 24 hours in advance (or at your first opportunity). This will enable us to help you with another appointment and to fill your slot with another patient in need. Without 24 hours notice, a $25.00 booking charge may be billed to your account to reserve future appointments because it deprives other patients of the appointment slot that we reserved for you.

INSURANCE

As a courtesy to our patients, we take care of all insurance billing. All insurance must be verified prior to use, which is why we collected your information when you made your appointment. To use your benefits, please complete the authorization portion below:

I AUTHORIZE THE FOLLOWING:

1. Use of this form on all my insurance and/or union claim submissions.
2. The release of my information to my insurance companies and/or unions.
3. My insurance and/or union benefits to be paid directly to Precision Eye Care.
4. A copy of this authorization to be used in place of the original.

I understand that my insurance company will not guarantee quoted benefits. Should my insurance company pay differently than was expected at the time of my visit or should they take more than 45 days to issue payment, I will be responsible for any balance. Should Precision Eye Care receive excess payment, I will be refunded. I understand that the co-pay and deductible portions are due at the time of the appointment.

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Signature

Consent to Discuss Medical Records

I authorize Precision Eye Care to discuss/provide copies of my medical/billing records to:

Only Myself or The Following individuals:

Printed Name	**Relationship to patient:**
______________________________________	____________________________________
______________________________________	____________________________________
______________________________________	____________________________________

Specifically, I authorize Precision Eye Care to share are limited to the following:

All my medical/billing records.

All medical/billing records dated from ___________________ to ____________________.

Only medical/billing records related to:

Most recent glasses and contact lens prescription (if applicable)

Contact lens fitting and follow-ups

Cataract surgery including preoperative and postoperative exams

Specialty procedures related to a glaucoma workup

Retinal evaluation

Other ____.

I understand that Precision Eye Care will only share the above information with the individuals listed above and that I can withdraw consent to authorize the release of information at any time by submitting a request to Precision Eye Care in writing to remove individuals from the above list.

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Signature

PRECISION
EYE CARE

Well-Screening Package

Our doctors consider our well-screening standard-of-care.

Skip the drops and test your peripheral vision to detect glaucoma, stroke, brain tumors, optic nerve disorders, retinal disease and more for just $54.

WELL-SCREENING		DILATION
Examines the retina for disease.		Examines the retina for disease.
Allows direct comparison to previous years.		Doesn't allow for direct comparison.
Can be sent to retinal specialist if needed.		Cannot be sent to retinal specialist if needed.
Does not cause blurred vision.		Blurs vision for 3+ hours, especially up close.
Allows you to return to work or school.		Requires that you take the rest of the day off.
Does not require that you have a driver.		May require that you have a driver.
Consists of six 1 -second flashes of light.		Consists of 5 continuous minutes of intense light.
Adds 5 minutes to your exam.		Adds at least 20 minutes to your exam.

Includes discounted retinal imaging ($39) and visual field screening ($15).
Save $61 on retinal imaging and visual field screening through this package!

Notice of Privacy Practices

Lisa Januskey OD, Privacy Official

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN OBTAIN ACCESS TO IT.

We respect our legal obligation to keep health information that might identify you privately. We are obligated by law to provide you with 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 we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on the answering machines, voice mails or emails; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax, or other electronic means including initial prescriptions and for continued requests from suppliers for refills, notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails, or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for your appointment.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payers in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT OBTAINING YOUR PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

1. When a state or federal law mandates that certain health information be reported for a specific purpose
2. For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices

3. Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
4. Disclosures for judicial and administrative proceedings, such as in response to a subpoenas or orders of courts or administrative hearings
5. Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
6. Disclosures to organizations that handle organ or tissue donations
7. Uses or disclosures for health related research
8. Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
9. Uses or disclosures to aid military purposes or lawful national intelligence activities
10. Disclosures of de-identified information
11. Disclosures related to a workman's compensation claim
12. Disclosures of a "limited data set" for research, public health, or health care operations
13. Incidental disclosures that are an unavoidable by-product or permitted uses and disclosures
14. Disclosures to business associates who perform health care operations for Precision Eye Care and who commit to respect the privacy of your information
15. Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Precision Eye Care for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Precision Eye Care staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Precision Eye Care staff and doctor will also infer that if you allow another person in an examination or treatment room with you while testing is performed or discussions held about your vision or health care that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Precision Eye Care or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign that authorization, you may revoke it an anytime. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information:

1. You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment or business operations. This request must be made in writing to the Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.
2. You may ask us to communicate with your in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Request for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

3. You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.
4. You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officers named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.
5. You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used in your treatment, payment, and business operations of Precision Eye Care. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of {$20.00} per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.
6. You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Precision Eye Care has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing or by phone. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make such a complaint.

I acknowledge that I have received a copy of Precision Eye Care's Privacy Policy.

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Signature

ATTESTION FORM

I attest that I reviewed and signed the following Precision Eye Care Forms on the date listed below:

- Practice Policies
- Consent to Discuss Medical Records
- Well-Screening Package
- Notice of Privacy Policies

____ ___________________

Patient Printed Name Date of Birth

____ ___________________

Guardian/Patient Signature Date