General Information

Thank you for allowing us to participate in your eye care. If you have insurance, we are committed to helping you receive your maximum allowable benefits. We understand that the insurance field can be quite confusing. Our financial policy is provided to assist you in understanding your responsibility to both The Eye Clinic Inc. and your insurance carrier. **Ultimately, all financial liability rests with the patient**. This includes but is not limited to routine vision exam, special testing or procedures such as OCT, HRT, Visual Field, Fundus Photography, Pachymetry, Topography, Ultrasound, Gonioscopy, Punctal Plug Insertion, or External Photos. Our technicians are able to explain any test or procedure that has been scheduled for you.

When you come to The Eye Clinic Inc. for your appointment, you will be asked to provide us with a photo ID and your insurance card. We will scan your insurance card for our records. You will also be asked to verify your address, telephone number, and insurance information. Please bring a full list of your current medications including dosages.

Patient Financial Policy

Refraction and Contact Lens exam & fee: A refraction is the process of determining your best-corrected vision. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. Our fee for the refraction is $28.00. The fee for a contact lens evaluation/ fitting may vary due to the complexity of the fitting and type of contact lenses. The refraction and contact lens evaluation/fittings are not a covered benefit by most insurance companies, including Medicare.

Insurance: Your insurance policy is a contract between you and your insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, any unpaid charges are your responsibility. You are expected to know and follow all regulations as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. **Any out of pocket expenses such as co-pays, coinsurance and deductible must be paid at the time of service.** Failure to provide copies of insurance cards may result in denial of your claim, and you will be held responsible for the balance. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered. If you do not have a valid referral, you will be asked to pay for the visit prior to your examination.**

Supplemental insurance: If you have supplemental insurance, we will send a claim to that company as a courtesy. Your signature on this form authorizes The Eye Clinic Inc. to bill and receive payment from your insurance company.

Worker's Compensation: In order for us to file a claim with Worker's Compensation, you must fill out all required paperwork which is available at our reception desk. We must have adequate information to bill either you MCO or Self-Insured plan. If you do not have this information available when you come in for your appointment, you will be responsible for all charges incurred until we receive this information from you.

Motor Vehicle Accidents: If you are involved in a motor vehicle accident, and you receive treatment from The Eye Clinic Inc., you will be responsible for payment of all charges incurred. We will provide you with a statement which you can turn into your medical or auto insurance carrier for reimbursement

No Insurance: Payment in full is due at the time of service

Methods of payment: We accept cash, check, Visa, MasterCard and Discover

NSF Checks: Any check that does not clear your bank account will result in a $25.00 fee

Refunds: If an overpayment has been made, a refund check will be issued to you. Overpayments for $5.00 or less will be credited to your account.

Statements: If there is a balance on your account after filing your insurance carrier, you will receive a statement. Payment is expected **by the due date** on your statement. If you have any questions regarding your statement, please contact the Billing department immediately. Your account will be considered delinquent after 30 days from your first statement. **Any debt old or new is expected to be satisfied to continue services with The Eye Clinic Inc. Failure to do so may result in dismissal.**

Services rendered to minor/dependent patients: For services rendered to minor patients, the parent(s) or guardian(s) of the minor are responsible for payment**.**

I have read and understand the financial policy of The Eye Clinic Inc. regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures. I addition, I understand that my signature authorizes the Eye Clinic Inc. to discuss my medical or other relevant information with my attending physician or my insurance carrier as needed.

_____

Patient signature/Guarantors Signature

Please state relationship to patient if you are signing on their behalf

_____

The Eye Clinic Inc. Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text will be presented to you upon request and is posted in our offices.

This notice describes how we, The Eye Clinic, Inc., use or disclose your Protected Health Information ("PHI"). PHI is information that identifies you and relates to health care services, the payment of health care services or your physical health or condition, in the past, present or future. This notice also describes your rights to access and control your PHI.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of PHI information with other healthcare providers for treatment, with health insurance payers who provide payment and for healthcare operations.
2. We are required to notify affected individuals following a breach of unsecured PHI.
3. We will not use or disclose your PHI without authorization, except described in our privacy notice.
4. We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the patient.
5. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
6. Your confidential information will not be sold to a business associate or any other third party without obtaining proper authorization.
7. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
8. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
9. You agree to bring any concerns or complaints regarding privacy to the attention of The Eye Clinic, Inc. privacy officer.
10. We agree to provide patients with access to their records in accordance with state and federal laws.
11. You have the right to a Personal Representative. You may identify persons to us who may serve as your authorized personal representative.
12. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
13. You have a right to inspect and copy your PHI upon request.
14. You have the right to request that we amend your records, if you believe that your PHI is incorrect or incomplete.
15. You may request an accounting of disclosures of your PHI made by us.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ **Date:** _____

(SIGNATURE)

_____

(PRINT NAME)

This notice is effective April 1, 2013

The Eye Clinic Inc.

Authorization for sharing Protected Health Information (PHI)

Due to HIPAA laws, we are not permitted to speak with anyone in regards to your care unless they are listed by our patient.

Please **PRINT** the name person(s) that you will allow us to speak to in regards to your personal medical information.

Name:

Relationship:

Contact #

Name:

Relationship:

Contact #

Name:

Relationship:

Contact #

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

The Eye Clinic Inc.
Leaders In Comprehensive Eye Care

Medical History Questionnaire

Name _____ Birth Date _____

Primary Care Physician _____

Diabetes Physician_____

List any medical or drug allergies and their reaction.

_____

_____

_____

_____

_____

List all medications currently taken (include dosage).

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Current occupation_____

Tobacco Use - □ Current □ Former □ Never □ Unknown

If you use tobacco, how many packs daily and for how many years?

_____ _____

Alcohol Use - □ Current □ Social □ Former □ Never

If you use alcohol, how many drinks daily and for how many years?

_____ _____

Do you live alone?	YES □	NO □
Do you drive?	YES □	NO □
Do you have visual difficulty when driving?	YES □	NO □
Do you have problems with night vision?	YES □	NO □
Do you currently wear glasses?	YES □	NO □

If YES, how long have you had the current pair? _____

Do you currently wear contact lenses?	YES □	NO □

Current Symptoms or Past Diagnosis and Medical History - Please mark all that apply.

GENERAL
□ Fatigue
□ Malaise (not feeling well)
□ Chills
□ Fever
□ Night Sweats
□ Appetite Changes
□ Weight Changes
□ Weakness

HEENT
□ Head injury
□ Decreased Hearing
□ Tinnitus
□ Earache
□ Hay Fever
□ Sinus Pain
□ Stuffiness
□ Discharge
□ Dry Mouth
□ Sore Throat

CARDIOVASCULAR
□ Angina
□ Heart Attack
□ High Cholesterol
□ High Blood Pressure
□ Low Blood Pressure
□ Murmur
□ MVP
□ Thrombophelebitis
□ Varicose Veins

PULMONARY
□ COPD
□ Wheezing
□ Cough
□ Hemoptysis
□ Asthma
□ TB
□ SOB

DERMATOLOGICAL
□ Rash
□ Lumps
□ Itching
□ Dryness
□ Rosacea
□ Dermatitis
□ Psoriasis

GASTROINTESTINAL
□ Diarrhea
□ Constipation
□ Stool changes
□ Hemorrhoids
□ Indigestion
□ Difficulty Swallowing
□ Acid Reflux

GENITOURINARY
□ Blood
□ BPH (Benign Prostotic Hypertrophy)
□ Difficult Urination
□ Enlarged Prostate
□ Increased Frequency
□ Frequent UTI's
□ Incontinence
□ Kidney Stones

ENDOCRINE
□ Polydipsia
□ Nervousness
□ Hypoglycemia
□ Goiter
□ Diabetes
□ Hair Loss
□ Heat/Cold Intolerance
□ Weight Changes

PSYCHIATRIC
□ Depression
□ Manic- Depression
□ Mania
□ Anxiety
□ Panic Attacks

HEMATOLOGICAL
□ Easy Bruisibility
□ Excessive Bleeding
□ Enlarged Lymph Nodes
□ Anemia

NEUROLOGICAL

□ Alzheimer's
□ Dizziness
□ Epilepsy
□ Headache
□ Migraines
□ MS
□ Neuropathy
□ Paralysis
□ Parkinson's Disease
□ Seizures
□ Stroke
□ TIAs
□ Tremor

MUSCULOSKELETAL

□ Arthritis
□ Muscle Weakness
□ Swelling
□ Leg Cramps
□ Stiffness
□ Back Pain
□ Joint Pain
□ Muscle Aches

PREVIOUS EYE DISEASE/PROBLEMS

_____

_____

_____

_____

FAMILY HISTORY	RELATION TO PATIENT	FAMILY HISTORY	RELATION TO PATIENT
□ Blindness	_____	□ Cataract	_____
□ Glaucoma	_____	□ Macular Degeneration	_____
□ Retinal Detachment	_____	□ Thyroid Disease	_____
□ Arthritis	_____	□ Unknown	_____
□ Alzheimer's disease	_____	□ Heart Attack	_____
□ Diabetes	_____	□ Kidney Disease	_____
□ Heart Disease	_____	□ Lupus	_____
□ High Blood Pressure	_____	□ Multiple Sclerosis	_____
□ Parkinson's disease	_____	□ Sjogrens Syndrome	_____
□ Asthma	_____	□ Stroke	_____
□ Emphysema	_____	□ Tuberculosis	_____
□ Cancer	_____		

LIST ANY PREVIOUS SURGERY INCLUDING EYE SURGERY **DATE**

_____ _____

_____ _____

_____ _____

_____ _____

What is the main reason for today's visit? _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING EYE SYMPTOMS?

EYES

□ Loss of vision
□ Distorted vision (halos)
□ Blurred vision
□ Loss of side vision
□ Double vision
□ Decreased vision
□ Mucous discharge
□ Redness
□ Sandy or gritty feeling
□ Itching
□ Dryness
□ Burning
□ Excessive tearing/watering
□ Occasional tearing
□ Glare/Light sensitivity
□ Eye pain or soreness
□ Chronic infection of eye/lid
□ Styes, Chalazion
□ Fluctuating visual acuity
□ Tired Eyes
□ Floaters
□ Flashes

Notice of Privacy Practice

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

This notice describes how we, The Eye Clinic, Inc., use or disclose your PHI ("PHI"). PHI is information that identifies you and relates to health care services, the payment of health care services or your physical health or condition, in the past, present or future. This notice also describes your rights to access and control your PHI.

The Eye Clinic Inc. Responsibilities

Federal law requires that we maintain the privacy of your PHI and provide to you with this Notice of our legal duties and privacy practices. We are required to notify affected individuals following a breach of unsecured PHI. We are required to abide by the terms of this Notice, which may be amended periodically. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain at The Eye Clinic, Inc. We will promptly revise and distribute this Notice wherever there is a change to the uses or disclosures, your rights, our duties, or other practices stated in this Notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new Notice in which the change is reflected.

How we may Use or Disclose PHI for Treatment, Payment, Health Care Operations

For Treatment. We may use or disclose your PHI to coordinate or manage your care within The Eye Clinic Inc. and with individuals or organizations outside of the Eye Clinic Inc. that are involved in your care, such as primary physician, other health care professionals, contracted service providers or any other related service organization. An example of this would include a service provider involved in your care may need information about your medical condition in order for us to deliver services properly.

To Obtain or Provide Payment. We may include you PHI in invoices to obtain reimbursement for services to any third parties, confirming coverage of benefits, billing or collection activities and utilization review. An example of this would be sending your bill from your visit to your insurance company.

To Conduct Health Care Operations. We may use and disclose PHI for our own operations and as necessary to provide quality care to all of our service recipients. Health care operations includes but is not limited to the following activities: quality improvement or assessment activities; activities designed to improve health or reduce health care costs; protocol development; professional review and performance evaluation, review and auditing, including compliance reviews; medical reviews, legal services and compliance programs; general administrative activities of The Eye Clinic, Inc. An example of this would be an internal quality assessment review.

How We May Use or Disclose for Appointment Reminders, Treatment Alternatives or Fundraising We may use or disclose your PHI to contact you as a reminder that you have an appointment for an office visit. We may use and disclose your PHI to advise you or recommend possible options or alternatives that may be of interest to you. At this time, The Eye Clinic Inc. will not contact you for Fundraising Activities.

Disclosures You May Authorize Us to Make We will not use or disclose your PHI without authorization, except described in this Notice. Subject to certain or limited exceptions, we may not use or disclose PHI for marketing without your authorization. We may not sell PHI without your authorization. You may give us written authorization to use and/or disclose health information to anyone for any purpose. If you authorize us to use or disclose such information, you may revoke that authorization in writing at any time.

Other Specific Uses or Disclosures

When Legally Required. We will disclose your PHI when required by any Federal, State or Local law.

In the Event of a Serious Threat to Life, Health or Safety. We may, consistent with applicable law and ethics standards of conduct, disclose your PHI if we, in good faith, believe that such disclosure is necessary to prevent or lessen a serious or imminent threat to your life, health, safety or to the health and safety of the public.

When there are Risks to Public Health. The Eye Clinic Inc. may disclose your PHI for public activities and purposes allowed by law in order to prevent or control diseases, injury or d or disability; report disease, injury and vital events such as birth or death; conduct public health surveillance, investigations and interventions; or notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

To Report Abuse, Neglect or Domestic Violence. We may notify government authorities if we believe a consumer is the victim of abuse, neglect or domestic violence. We will make this disclosure only when required or authorized by law, or when the consumer agrees to the disclosure.

To Conduct Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary actions. However, we may not disclose your PHI if you are the subject of an investigation and your PHI is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. We may disclose your PHI in the event of any judicial or administrative proceeding in response to an order of a court or administrative hearing as expressly authorized by such order or, or, a response to a subpoena, discovery request or other lawful process, if we determine that reasonable efforts have been made by the party seeking the information to either notify you about the request or to secure a qualified protective order regarding your health information.

Under Ohio law, some requests may require a court order for the release of any confidential medical information.

For Law Enforcement Purposes. As permitted or required by law, we may disclose specific and limited PHI about you for certain law enforcement purposes.

For Research Purposes. We may, under select circumstances, use your PHI for research. Before The Eye Clinic Inc. discloses any of your PHI for such research purposes in a way that you could be identified, the project will be subject to an extensive review and approval process, unless otherwise prohibited by Medicaid.

For Specified Government Functions. Federal regulations may require or authorize us to use or disclose your PHI to facilitate specified government functions relating to military and veterans; national security and intelligence activities; protective services for the President and others; medical suitability determinations; and inmates and law enforcement custody.

For Workers' Compensation. We may use or disclose your PHI for workers' compensation.

Transfer of Information at Death. In certain circumstances, we may disclose your PHI to funeral directors, medical examiners and coroners to carry out their duties consistent with applicable law.

Organ Procurement Organizations. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purposes of tissue donation and transplant.

Your Rights with Respect to PHI

Right to a Personal Representative. You may identify persons to us who may serve as your authorized personal representative, such as a court-appointed guardian, a properly executed and specific power-of-attorney granting such authority, a Durable Power of Attorney for Health Care **If** it allows such persons to act when you are not able to communicate on your own or other method recognized by applicable law. We may, however, reject a representative if, in our professional opinion that it is not in your best interest.

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have a right to request a limit on our disclosure of your PHI to someone who is involved in your care or the payment of your care. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it unless the request concerns a disclosure of PHI to a health plan for purposes carrying out payment or health care operations and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full. To request such restrictions, please contact the Privacy Officer at 330-837-5191.

Right to Confidential Communications. You have the right to request that we communicate with you in a confidential manner. For example, we may ask to discuss

your medical care confidentially without any other family members present. If you wish to receive confidential communications, please contact the Privacy Officer ay 330-837-5191.

Right to Inspect and Copy your PHI. Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your PHI upon request. You have the right to inspect and copy such health information, including billing records, at a reasonable time and place. A request to inspect and copy records containing your PHI may be made to the Privacy Officer at 330-837-5191. If you request a copy of such health information, we may charge you a reasonable copying, processing and personnel fees.

Right to Amend your PHI. You have the right to request that we amend your records, if you believe that your PHI is incorrect or incomplete. The request may be made as long as we maintain the information. A request for an amendment of records must be made in writing to the Privacy Officer at 3545 Lincoln Way East, Massillon, OH 44646. We may deny the request if it is not in writing, or does not include a reason for the amendment. The request also may be denied if your health information records were not created by us, if the records you are requesting are not part of our records, if the health information you wish to amend is not part of the health information that you are permitted to inspect and copy, or if, in our opinion, the records containing your health information is accurate and complete. We take the position that amendments may take the form of including a written statement from you and may not include changing, defacing or destroying any necessary information related to your health care.

Right to Know what Disclosures Have Been Made. You have the right to request an accounting of disclosures of your PHI made by us for certain reasons, including reasons related to public purposes authorized by law, and certain research. The request for an accounting must be made in writing to the Privacy Officer at 3545 Lincoln Way East, Massillon, OH 44646. The request must specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years prior to the date on which the accounting is requested. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a cost based fee.

Right to a Paper Copy of this Notice. You have a right to receive paper copy of this Notice at any time, even if you have received this Notice previously. To obtain a paper copy, please contact the Privacy Officer at 330-837-5191.

<u>Where to file a complaint</u>

You have the right to complain to us if you believe that your privacy rights have been violated, including the denial of any rights set forth in this Notice. Any complaints to us shall be made in writing to the Privacy Officer at 3545 Lincoln Way East, Massillon, OH 44646. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C., 20201 or call toll free 877-696-6775, by email to OCRComplaint@hhs.gov, or to Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL., 60601, Voice Phone 312-886-2359, Fax 312-886-1807 or TDD 312-353-5693.

Contact Persons

We have designated the Privacy Officer as our contact point for all issues regarding consumer privacy and your rights under this Notice. If you have any questions regarding this Notice, please contact the Privacy Officer:

The Eye Clinic Inc.
Privacy Officer
3545 Lincoln Way East
Massillon, OH 44646
330-837-5191
Toll Free: 1-877-696-6775

Effective Date

This notice is effective April 1, 2013

If you have any questions regarding this notice, please contact the Privacy Officer at 837-5191.330-