Notice of Privacy Practices

Eyes in the 'Burg
August 29, 2023

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. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not sell or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time by letting us know in writing.

Who Will Follow This Notice: Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries and business associates of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information to your insurance company for payment.

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues. We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy policy.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you for workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Use and Disclosures of Protected Health Information Requiring Your Written Authorization. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the care we have provided you.

Your Rights

When it comes to your health information, you have certain rights. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201. We will not retaliate against you for filing a complaint.

Right to an electronic or paper copy of our medical record. You may request an electronic or paper copy of your medical record and other health information that we have about you. We will provide a copy to you as soon as possible or within 15 days of your request.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You must submit your request for an amendment in writing to this practice and provide a reason to support the request. In addition, we may deny your request if the information was not created by us or if we deem it to be accurate and complete.

Right to Request Restrictions. You can ask us not to use or share certain health information for treatment, payment, or health care operations. We are not required to agree to your request, and we may say no if it would affect your care. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to this practice. In your request, you must tell us what information you want to limit. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of disclosures we made of medical information about you. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before January 1, 2013.You must submit your request in writing to the Privacy Officer at this practice and should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to a Paper Copy of This Notice. You have the right to a paper 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. To obtain a paper copy of the current Notice, please request one from any employee of this practice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices 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 generate in the future. If we change our Notice of Privacy Practices, we will post the new one on our website and have copies available in office.

□ I acknowledge that I received a copy of Eyes in the 'Burg Notice of Privacy Practices.

Personal Care Representative:

□ **I do NOT authorize anyone to act as my personal representative.**

□ **I do authorize you to discuss my protected health information with the following individual(s) acting as my personal care representative.**

Name: _____ Date of Authorization:_____

I authorize to disclose my protected health information with the following individual(s) listed below:

Name: _____ Date of Authorization:_____

Relationship: _____

Name: _____ Date of Authorization: _____

Relationship: _____

Consent for Electronic Communication.

Your health care is important to us. In order to provide you with the best possible care, we occasionally send convenient electronic messages to our patients about their health care and the products and services we offer. We want to make sure you know that unencrypted email and text communications are not secure. We will limit information sent via text message to the minimum necessary. . These messages may include appointment reminders or product pickup notices. ELECTRONIC COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION. This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization.

□ **I do NOT wish to be contacted by email or text.** **Email:_____**

□ **I do consent to being contact by email or text.** **Cell #:_____**

Consent for billing.

I understand that the patient portion is due at the time services are rendered, unless other arrangements are made in advance. I acknowledge that I am ultimately responsible for any bills incurred in this office regardless of insurance. I understand that Eyes in the 'Burg will bill my insurance company on my behalf and payments from my insurance company are to be paid directly to Eyes in the 'Burg. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made once the claim is processed.

□ **I authorize Eyes in the 'Burg to charge my credit card on file for any balance that is not covered by my insurance. You will be notified of the balance to be charged one week before and can make alternate arrangements with our office if needed. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until canceled.**

□ **I do NOT authorize Eyes in the 'Burg to charge my card on file and agree to pay my bill promptly upon receipt.**

Patient Name:_____ Date: _____

Signature of Patient or Legal Surrogate:_____