Southside Center for Sight Policies

701 E County Line Rd Suite 202 Greenwood IN 46143 317-215-2833

- Notice of HIPAA Privacy Practices
- Waiver of Insurance Liability
- Fees for Refractions, Contact Lens Evaluations and Contact Lens Fittings
- A Statement Regarding Dilation of Your Eyes
- Physician's Disclosure of Financial Interest

Effective date of notice: 2/15/16
Account#___________________

Notice of Privacy Practices **Form 7.20**

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure of accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Address: Southside Center for Sight
Attn: Privacy Manager
701 East County Line Road, Suite 202
Greenwood, Indiana 46143
Phone: 317-215-2833

We will not retaliate against you for filing a complaint.

Waiver of Insurance Liability

I acknowledge that the insurance information I have provided is the insurance for which I am currently eligible. I understand that I will be responsible for payment in full for all visits/procedures if not covered by insurance or if this information is incorrect.

I authorize Southside Center for Sight to furnish information concerning my illness or medical treatment to the insurance carrier I provided and hereby assign to the provider all insurance payments for medical services rendered to me. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility.

I understand that there will be a $25.00 handling fee assessed for any and all checks returned due to non-sufficient funds or account closure. In the event a collection agency is required to obtain funds, I agree to reimburse the fees of the collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I also understand that I will be assessed a late fee of $5.00 per month on any outstanding balance unless other arrangements have been made.

Fees for Refractions, Contact Lens Evaluations and Contact Lens Fittings

Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. A Contact Lens Evaluation or Fitting is an examination of the curvature of your eye and is necessary to establish the best power, type and fit of a contact lens for the patient.

Most medical insurance plans, including Medicare, do NOT cover routine Refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for the Refraction portion of the examination, since it is not a covered service. Contact Lens Evaluations and Contact Lens Fittings are not covered services by Medicare or commercial insurance companies.

Our office fee for Refractions is $50 and our fees for Contact Lens Evaluations and Fittings will vary according to the type of diagnosis and/or contact lens needed.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement:

I have read the above information and understand that if the refraction is a non-covered service I accept full financial responsibility for the cost of this service. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

A Statement Regarding Dilation of Your Eyes

We would like to inform our patients that it may be necessary during the course of your exam to dilate your eyes with drops. In some people, the dilating drops cause blurred vision, light sensitivity and inability to read. These problems go away as the effects of the drops wear off. This usually lasts 4-6 hours. You should be careful walking, going up and down stairs, and should not drive a car. In very rare cases, the drops may cause elevated eye pressure requiring further treatment.

It is for this reason that we recommend someone come with you as a driver at the time of your exam. Also, for your comfort, you may obtain dark glasses at the reception desk.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye examination.

Physician's Disclosure of Financial Interest

While you are a patient, you, or the named patient for whom you are a legal representative, may be referred to one of the health care entities listed below in which Dr. Christopher Pesavento has a financial interest. In each case, you may choose to be referred to another health care entity if you so desire.

Indiana Surgery Center South

And

Franciscan Surgery Center

Patient Acknowledgement:

I, the named patient or legal representative of such patient, hereby acknowledge receipt of, on the date indicated below, a copy of the foregoing Physician's Disclosure of Financial Interest.

Acknowledgement of Receipt

I, the named patient or legal representative of such patient hereby acknowledge receipt of the following policies, on the date indicated below and agree to all policies:

- *Notice of HIPAA Privacy Practices*
- *Waiver of Insurance Liability*
- *Fees for Refractions, Contact Lens Evaluations, and Contact Lens Fittings*
- *Statement Regarding Dilation of Your Eyes*
- *Physician's Disclosure of Financial Interest*

You will sign electronically on date of visit. You may keep this copy for your records.