PREMIER VISION
OPTOMETRY

HIPAA Notice of Privacy Practices

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. This Notice Of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your demographic information that may identify you and that relates to your past, present or future physical and mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your PHI may be used and disclosed by your doctor, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for the procedure.

Health Care Operations

We may use or disclose, as needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical/optometry students, licensing, and conduction or arranging for other business activities. For example, we may disclose your PHI to optometry school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI without your authorization in these situations: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Acknowledgement of Financial Responsibility

You as a patient, are ultimately responsible for all fees. We do accept insurance assignment and can file your insurance claim for you; however, you are still responsible for all co-payments or balance as required by your specific insurance plan. You are required to bring your insurance card to each visit. If your insurance requires a referral, this must be obtained from your primary care physician prior to coming into our office. All co-payment and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary co-payments, co-insurance and deductibles. We accept cash, check or credit card. We will try to obtain pre-approval for treatments and procedures from your insurance company; however, if the insurance company refuses to pay for any reason, you are ultimately responsible for the fees of treatments and procedures.

My signature below acknowledges that the HIPPA Notice of our Privacy Practices has been received, read and understood by me, and I will be ultimately responsible for all the fees for office visits, treatments and procedures.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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