Tri-County Eye Care tricountyeye2@gmail.com

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 READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities and Business Associates that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

What is Protected Health Information? Protected health information is any information that relates to your past, present, or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for the provision of health care to you. This protected health information individually identifies you or can be used to identify you. Medical records, insurance information, and billing records are examples of protected health information.

How we may use and/or disclose your health information:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assess ments and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards or a sign-in sheet at the check-in desk where you will be asked to sign your name. We may also call you by name in any waiting area.

- Business Associates are separate entities contracted by us to provide a service. They may have access to your information, but are required to treat your PHI in the same manner we do. Examples may include answering services, accounting firms, or computer software providers.

- We may disclose information to individuals involved in your care or responsible for the payment of your care, such as a spouse, a family member, or close friend that you have authorized to receive this information. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your post-operative care. Please inform us when you do not wish an individual to receive your health information.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons, although we shall do our best to assure its continued confidentiality to the extent possible. Other examples may include disclosures to healthcare oversight and public health reporting agencies, and other mandatory reporting requirements.

- The practice may use your PHI to send you appointment reminders and recall notices via telephone or mail. We may telephone you at any telephone number provided to us. We may leave a message with someone at your telephone number or on your answering machine stating with future appointment information. In regards to treatment or payment, we may leave a message for you to call us.

- We may use your health information for the purposes of research, teaching, and training. *(continued)*

Monica Redmond, O.D.
3685 Burgoyne Ave., Hudson Falls, NY 12839
(518) 747-4100

- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. if we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our Practice's Privacy Officer and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Privacy Officer for more information, in person or in writing.

Tri-County Eye Care

tricountyeye2@gmail.com

Dear New Patient,

Welcome! Thank you for choosing Tri-County Eye Care for your eye health care.
In order to expedite your initial reception process, please complete the enclosed new patient information forms and bring them when you come for your first appointment.
This information is important in coordinating your care.

Your eyes may be dilated for your eye exam, which makes the pupils of your eyes large for several hours and may cause light sensitivity, glare, and blurred vision. If you don't have dark glasses, please ask us for a pair!

Please bring the following to your appointment:

____ Signed Patient Consent and Disclosure Form

____ Signed Financial Policy

____ Completed Patient History Form, including a list of all medications and eye drops that you are taking

____ Current insurance cards (medical and vision insurances) and a valid photo ID

____ Payment for copays and deductibles (cash, check, American Express, Discover, MasterCard, Visa)

____ Ensure that your primary care physician has submitted a referral if required by your insurance

**Note:* Without the required referral, your appointment may need to be rescheduled.

if you have any questions, please do not hesitate to call us at the number listed below. Visit us on the web at **www.tricountyeye2@gmail.com** for additional information and updates. Again, we extend our warmest welcome to you and your family.

Monica Redmond, O.D.
3685 Burgoyne Ave., Hudson Falls, NY 12839
(518) 747-4100

Patient Name: ______________________
DOB: __________________

Tri-County Eye Care

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PATIENT CONSENT AND DISCLOSURE AUTHORIZATION

- By signing this PATIENT CONSENT AND DISCLOSURE AUTHORIZATION, the patient or legal guardian of a minor patient understands and acknowledges that Tri-County Eye Care is committed to securing the privacy of health information. Accordingly, we have posted our **Notice of Privacy Practices** in our offices and the patient has been provided the opportunity to take a copy.

- The HIPAA Privacy Rule gives the individual the right to request the release of Protected Health Information (PHI) to identified individuals.

- I authorize my PHI to be disclosed to the following individuals only:

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

Lifetime Signature on File and Assignment of Benefits:

I request that payment of any and all authorized insurance benefits be made on my behalf to Tri-County Eye Care for professional services rendered. I authorize Tri-County Eye Care to release information about me to any private insurance carrier and/or to the Centers for Medicare and Medicaid Services (CMS) required to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, including copays, coinsurance, deductibles, and non-covered services.

_____________________________________ ____________________________ ____________

Print Name | Signature | Date

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(518) 747-4100

Patient Name: ______________________
DOB: __________________

Tri-County Eye Care

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FINANCIAL POLICY

Thank you for choosing Tri-County Eye Care as your health care provider. We are committed to building a successful relationship with you and your family. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. You are asked to sign this acknowledgement stating you have read and agree to our Financial Policy prior to services being rendered.

Insurance:
We participate with most medical plans, as well as a variety of vision plans. It is important to understand that insurance is an agreement between you and your insurer. It is your responsibility to be aware of the limitations of your plan and what you may be responsible for financially.

If we participate with your insurance, all services will be submitted to your carrier for you. **We will collect copayments, deductibles and coinsurance for all covered services and your complete payment for non-covered and self-pay services at the time of service.** We do not submit claims for those services your insurer has deemed .noncovered" or you deem "self-pay". **Be advised that routine visits and refraction services are often noncovered. There are many plans including Medicare and Medicaid that do not cover routine visits and refraction services.** Please bring a form of payment with you to each visit to avoid additional fees.

If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. If the referral is not present at the time of your appointment you may do one of the following:

- Reschedule the appointment until the referral is obtained.
- Contact your primary care physician by use of our courtesy phone. Your referral will need to be verified before you receive services.

It is your responsibility to ensure that the doctor you are scheduled with participates in your plan and that the visit or procedure is a benefit of your plan. If we do not participate with your insurance, you have a deductible plan or the service is non-covered, payment is expected at the time of service.

Outstanding Balances and Collection:
We accept Cash, personal checks, and credit cards. All payments, including deductibles, are expected at the time of service. **All outstanding balances are due upon receipt of the first statement and must be paid In full prior to receiving additional services or materials.** If you are unprepared to pay at the time of service, we may add a billing charge of $10.00 to your encounter. In addition, 30 days from the date of service, interest fees up to 1.5% may be applied to each unpaid encounter. There may be a fee up to $40.00 for checks returned by your bank. You may receive a delinquent letter if your balance is not paid in 90 days. Unpaid balances over 90 days may be sent to a collection agency and may incur additional collection and processing fees up to 33%.

I have read the Financial Policy of Tri-County Eye Care and agree to the terms set forth herein.

______________________________	______________________	__________
Print Name	Signature	Date

Monica Redmond, O.D.
3685 Burgoyne Ave., Hudson Falls, NY 12839
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Patient Name: ______________________
DOB: __________________

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What is the difference between Vision Insurance and Medical Insurance?

Vision Insurance (Vision Plans)
It is important that you understand that your Vision Plan (VSP and EyeMed, etc.) covers ROUTINE well-eye exams only, which includes the refraction to determine your eyeglass prescription. Your plan may also provide discounts or allowances toward eyeglass frames, lenses, or contact lenses.

As part of a routine well-care exam, the doctor examines your eyes for routine eye health and to determine the need for glasses or other refractive correction. If a medical eye condition is known, or discovered during this exam, a separate exam must then be made to address these issues and will be filed under your medical insurance. If your routine well-eye examination reveals a medical condition or disease which requires special testing or follow-up care, the testing and subsequent examinations will be billed to your medical insurance as these are **NOT COVERED** by your Vision Plan.

It is important to know that if you have a specific eye or vision complaint which is related to a new or pre-existing condition, such as cataract, glaucoma, diabetes, dry eyes, etc. or if you are here for a follow up appointment for a pre-existing condition as requested by a doctor, then your visit is **NOT COVERED** by your Vision Plan and will be billed to your medical insurance. Unfortunately, the doctor cannot always be sure whether a complaint such as decreased vision is related to a medical eye condition until after you are thoroughly examined.

Medical Insurance
The good news is that your Medical Insurance can be used if you have an eye-related medical problem, such as an eye injury, pink eye, double vision, headaches, cataract, dry eyes, glaucoma, or issues related to diabetes or high blood pressure (among many others). You **DO NOT** need a vision benefits rider on your medical insurance to be covered for a medical eye condition. In these cases, your Medical insurance will be billed for the eye exam *even though a Vision Plan may also be in effect.* Your Medical insurance co-pays and deductibles prevail and must be paid at the time of your examination. Additionally, if we do file the exam with your medical insurance, you can still use your Vision Plan benefits toward the purchase of glasses or contact lenses, based on your plan and allowances.

At times it can seem like a complicated process, but these are the rules set by the insurance companies.
We would be happy to answer any questions that you may have about your coverage.

Once your exam has been filed with your insurance provider (at the conclusion of your visit) we CANNOT ALTER or CHANGE your examination documents or diagnosis codes or bill the other insurance.

I have read the notice of Tri-County Eye Care, and agree to the terms set forth herein.

____

Signature of Patient and/or Guardian *Date*

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Tri-County Eye Care

Patient History Form

Title: ______ First Name: ________________________ Last Name: ________________________

Date of Birth (DOB): ____/____/____ SS#:______-_____-______ Home Phone#: (_____)______-_________ Cell Phone#: (______) ______ - ________

Address ________________________ City ________________ State ____________ Zip___________

Gender ☐ Male ☐ Female ☐ Other

Emergency Contact: ________________ Phone: ____________ Relationship: ________________

Primary Care Physician: ________________ Referred by (if other than PCP): ________________

Pharmacy Name/Location: ________________ Phone Number: ________________

Employer: ________________ Email address: ________________

If you are a new patient, date of last eye exam: ________________

Reason for today's visit (symptoms): ________________

List any significant eye conditions and surgeries with dates (cataracts, macular degeneration, diabetic retinopathy, glaucoma, injuries to the eye, lasers, injections, lazy eye, crossed eyes, etc.):

____

MEDICAL HISTORY - Have you ever had any problems in the following areas?

☐ Yes ☐ No Diabetes	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Anemia
☐ Yes ☐ No Degenerative arthritis	☐ Yes ☐ No Hiatal hernia	☐ Yes ☐ No Leukemia
☐ Yes ☐ No Rheumatoid arthritis	☐ Yes ☐ No Ulcers	☐ Yes ☐ No Sickle cell disease
☐ Yes ☐ No Alzheimer's Disease	☐ Yes ☐ No Skin disease	☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No migraines	☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Emphysema
☐ Yes ☐ No Convulsions/seizures	☐ Yes ☐ No Pregnant	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Stroke/paralysis	☐ Yes ☐ No Congestive heart failure	☐ Yes ☐ No Sarcoidosis
☐ Yes ☐ No Parkinson's Disease	☐ Yes ☐ No Heart mumur	☐ Yes ☐ No Immune problems
☐ Yes ☐ No Multiple sclerosis	☐ Yes ☐ No Heart attack	☐ Yes ☐ No High cholesterol
☐ Yes ☐ No Schizophrenia	☐ Yes ☐ No Irregular/fast heartbeat	☐ Yes ☐ No cancer - please specify
☐ Yes ☐ No Lupus	☐ Yes ☐ No High blood pressure	

List any surgeries with dates: ____

____

FAMILY AND SOCIAL HISTORY:

Eye Diseases	Relationship to patient	Medical Diseases	Relationship to patient	Medical Diseases	Relationship to patient
☐ Amblyopia (lazy eye)		☐ Arthritis		☐ Respiratory disease	
☐ Blindness		☐ Asthma		☐ Stroke	
☐ Cataracts		☐ Cancer		☐ Thyroid disease	
☐ Corneal disease		☐ Circulatory disorders		☐ Tuberculosis	
☐ Glaucoma		☐ Diabetes		☐ Other	
☐ Macular Degeneration		☐ Heart attack			
☐ Retinal detachment		☐ Heart disease			
☐ Retinal disorders		☐ High blood pressure			
☐ Strabismus		☐ Kidney disease			

Tri-County Eye Care

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Patient History Form

Patient Name: ______________________________ DOB:____/____/______

Medical Insurance:

Name of Insurance Company ______________________________
Name of Cardholder ______________________________
ID #______________________________
Insured's DOB ______________ Insured's Employer ______________
Relation to patient ______________ Insured's SS# ______________

Vision Insurance:

Name of Insurance Company ______________________________
Name of Cardholder ______________________________
ID #______________________________
Insured's DOB ______________ Insured's Employer ______________
Relation to patient ______________ Insured's SS# ______________

ORAL MEDICATIONS you take(prescription and over the counter). Attach a list if necessary.

Name of Medication	Dosage	Start Date

Do you drink alcohol? ❑ Yes ❑ No

How much?________ How often?________

Intake of caffeine drinks/supplements? ❑ Yes ❑ No

How much?________ How often?________

Do you use drugs? ❑ Yes ❑ No

❑ Former ❑ Never Type?______________

Do you smoke or use tobacco? ❑ Yes ❑ No

❑ Former ❑ Never Type?______________

OCULAR MEDICATIONS:

List all EYE medications you take (prescription and over the counter). Attach a list if necessary.

Name of Eye Medication	Dosage	Start Date

MEDICAL/SEASONAL ALLERGIES.

❑ Check here if you have no known allergies.

Allergen	Reaction	Severity

❑ Yes ❑ No	Do you work on a computer?
❑ Yes ❑ No	Do you wear glasses?
	If yes, for ❑ Distance ❑ Near ❑ Both
	How old are they?
❑ Yes ❑ No	Do you like wearing glasses?
❑ Yes ❑ No	Do you have contact lenses?
❑ Yes ❑ No	If no are you interested in contact lenses?

How old are your contact lenses?	
What solution do you use?	
❑ Yes ❑ No	Have you had refractive surgery?
❑ Yes ❑ No	If no, are you interested in the procedure?