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NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

The new Federal HIPAA (Health Insurance Portability and Accountability Act) is designed to protect your health information. Due to the rapid increase of computer technology in health care the Federal government has sought to standardize and protect the electronic exchange of your health information.

We will use and communicate your health information only for the purposes of providing treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been given your permission.

To Provide Treatment:
We use your health information in our office to provide you with the best care possible. This includes administrative and clinical office procedures such as scheduling, reminders, insurance audits, quality assurance and compliance reviews. We may also share your information with referring physicians, primary care and specialty care physicians providing you treatment, pharmacies, medical material suppliers, and pharmacies.

To Obtain Payment:
We may use your health information, such as diagnostic and treatment codes, to collect payment from insurance companies and third party payors, or so that you may receive reimbursement. We may do this with insurance forms filed by mail, fax, or sent electronically.

Domestic Violence, Abuse, and Neglect:
When we are compelled by our ethical judgment, and when we are required or authorized by law, we will notify appropriate authorities.

Law Enforcement, Public Health, and National Security:
When required by State or Federal Law, we may disclose your health information to law enforcement officials, federal officials, or military authorities.

Family, Friends, and Caregivers:
At your request, we may disclose health information, treatment and payment options to those involved in your medical care, or to those that are present at the time of your examination. We may ask you to sign a written “authorization form” before we agree to disclose your information. We may also ask you to relay the information personally to another party. You may revoke your authorization in writing at any time.

Patient Rights

You have the right to request restrictions on certain uses and disclosures of your health information.

You have the right to request that we communicate with you in a certain way, such as privately with no other family members present or through mailed communications that are sealed.

You have the right to read, review, and copy your health and billing records. A reasonable fee will be charged for any administrative, copying or mailing costs associated with the inspection or duplication of your health care information.

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations.

You have the right to request in writing that a change be made to your health care information if you believe that it is inaccurate or incomplete.

You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

You have the right to submit a written complaint to us, or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated.

We reserve the right to change this notice or our Privacy Practices at any time as allowed by law.

Patient Acknowledgement

Patient Name(s): ______________________________

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I acknowledge receipt of the Notice of Privacy Practices from Eyeworks, Ltd.

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Patient Signature *Date*