ACKNOWLEDGEMENT OF HIPAA POLICIES AND PROCEDURES MANUAL,
PRIVACY POLICY AND AUTHORIZATION FOR DISCLOSURE OF **PHI**
(Protected Health Information)

Patient: Date of birth/Account number

_______________________________ _______________________________

By signing this form, you acknowledge that Keystone Eye Associates, LLC, has given you an opportunity to review their HIPAA Policies and Procedures Manual, Privacy Policy, and Disclosure of PHI in various situations, and authorize Keystone Eye Associates, LLC, to release authorized information. This form must be signed as a key part of Keystone Eye Associates, LLC's federal privacy compliance program.

Is there any medical information you do not want disclosed? Yes_ or No_ if yes information you do not want disclosed____.

Another person we can release information to on your behalf: _________________________ ____.

Purposes for need of disclosure:

Further medical care
Legal Investigation or Action
Personal
Insurance Eligibility/Benefits
Changing Physicians

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting ___Apryl Palen___________________. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact:___Apryl Palen___________________________. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good for one year from the date signed.

I have been given an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: ____

Date: _______________

(If signed by other than patient, state relationship and authority to do so.)

NOTICE OF PROVIDER PRIVACY PRACTICES

For Keystone Eye Associates, LLC

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.

Effective Date: March 31, 2016

Keystone Eye Associates, LLC must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. We must follow the privacy practices described in this notice. If you have any questions about this notice, please contact the privacy officer, Apryl Palen.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

How We May Use And Disclose Health Information

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer, Apryl Palen.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

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KEYSTONE EYE ASSOCIATES

Patient Information: **Date:** ____________

Last Name: ______________________ **First Name:** ______________________ **MI:** ___

Prefix:______________ **Suffix**______________ Male ☐ Female ☐

Date of Birth: ______________________ **Social Security #:** ______________________

Home Address: ____ **Apt#**__________

____

City: ______________________ **State:** ____________ **Zip Code:** ____________

Home Phone: ______________________ **Cellular Phone:** ______________________

E-Mail: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced/Widowed

Employer & Occupation: ______________________ **Work #:** ______________

Emergency Contact: ______________________ **Relationship:** ______________

Emergency Contact Phone: ______________________

Insurance Plan: ______________ **ID#:**______________ **Group#:** ______________

Who may we thank for referring you to us? ______________________________

Who is your Primary Physician? ______________________ **Phone:** ______________

Who is your Optometrist? ______________________ **Phone:** ______________

Financial Assignment and Agreements

- I acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, possibly making driving difficult. Please ask for assistance if your vision is significantly affected.
- I request that payment of authorized Medicare and /or insurance benefits be made on my behalf to Keystone Eye Associates for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration, it's agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.
- I understand that I am financially responsible for all charges not covered by insurance. This includes any deductibles or co pays.
- Keystone Eye Associates participates in many insurance plans. We do our best to learn as many of their requirements as possible. However, it's not always possible. Please make sure that you understand your insurance and their requirements.
- Medical insurances (ie. Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.
- I authorize Keystone Eye Associates to communicate with me by phone, answering machine, written correspondence or E-mail at home or business regarding appointments, care or billing.
- I agree to the release of my medical information to my personal physician(s) or optometrist (s).
- I give permission to discuss my medical information with the specific individuals named below: (ie. Spouse, adult children, care giver, emergency contact)

  1.______________________ 2.______________________
- I acknowledge that a copy of **Keystone Eye Associates** privacy policy has been provided to me for review and that a copy is available upon my request.
- I understand the above and agree to abide by the regulations of my insurance company and the policy of Keystone Eye Associates.

Signature: ______________________________________ Date: ______________

(Patient or Legal guardian)

Witness: ______________________________________ Date: ______________

KEYSTONE EYE ASSOCIATES
Medical History Form

NAME: ______________________ **DOB:** ____________ **DATE:** ____________

KEA Acct. #: ______________________ **Date of Prior HX Form:** ____________

OCULAR HISTORY:

Have **YOU** ever been diagnosed with any of the following eye problems:

☐ Y ☐ N Glaucoma
☐ Y ☐ N Macular Degeneration
☐ Y ☐ N Dry Eyes
☐ Y ☐ N Retinal Detachment
☐ Y ☐ N Cataracts
☐ Y ☐ N Diabetic Retinopathy
☐ Y ☐ N Lazy Eye

EYE DROPS OR EYE MEDICATIONS:

____
____
____
____
____

EYE SURGERIES/LASERS: (PLEASE LIST TYPE OF SURGERY AND DATE)

____
____
____
____
____

PATIENT MEDICAL HISTORY:

Do **YOU** have any of the following **medical** problems (please check yes or no):

☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Diabetes
☐ Y ☐ N Heart Disease
☐ Y ☐ N Cancer
☐ Y ☐ N Asthma/Emphysema
☐ Y ☐ N Stomach Disorders
☐ Y ☐ N Kidney Disease
☐ Y ☐ N Neurologic/Strokes
☐ Y ☐ N Blood Disorders
☐ Y ☐ N Frequent Fatigue
☐ Y ☐ N Sleep Apnea
☐ Y ☐ N Arthritis
☐ Y ☐ N Migraines
☐ Y ☐ N Depression
☐ Y ☐ N Shingles
☐ Y ☐ N Thyroid
☐ Y ☐ N Sinus Infections
☐ Y ☐ N Hard of Hearing
☐ Y ☐ N Cholesterol
☐ Y ☐ N Skin Disorders
☐ Y ☐ N Weight loss/gain
☐ Y ☐ N Pacemaker/Defibulator

ALLERGIES:

Seasonal?	☐ Y	☐ N	______
Latex/Environmental?	☐ Y	☐ N	______
Drug/Other?	☐ Y	☐ N	______

SYSTEMIC MEDICATIONS:

______
______
______
______
______
______
______

SOCIAL HISTORY:

Do you drive?	☐ Yes	☐ No	Comment: ______
Do you smoke?	☐ Yes	☐ No	Packs per day: ______
Do you drink alcohol?	☐ Yes	☐ No	Amount: ______
Do you presently exercise:	☐ Yes	☐ No	Comment: ______

FAMILY HISTORY: (Do any of your Blood Relatives have the following? If yes, state relationship)

☐ Y	☐ N	Diabetes	______
☐ Y	☐ N	Glaucoma	______
☐ Y	☐ N	Macular Degeneration	______
☐ Y	☐ N	Amblyopia (Lazy Eye)	______
☐ Y	☐ N	Retinal Detachment	______
☐ Y	☐ N	High Blood Pressure	______
☐ Y	☐ N	Heart Disease	______
☐ Y	☐ N	Strokes/Neurological Disease	______
☐ Y	☐ N	Cancer	______

Technician: ______

Doctor: JSS, JSJ, DS, LS, NB, MD, AC, CM, JB, LN, LR

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

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Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

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Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses And Disclosures That Requires Us To Give You An Opportunity To Object And Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your Written Authorization Is Required For Other Uses And Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information,

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you must make your request, in writing, to Apryl Palen. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Apryl Palen.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Apryl Palen.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Apryl Palen. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Apryl Palen. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a 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 of this notice. You may obtain a copy of this notice at our web site. To obtain a paper copy of this notice, you must make your request to Apryl Palen.

Changes To This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Apryl Palen. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

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