

Welcome to Eye Care of East Bay



Vahid Feiz, MD

Board Certified

Cornea, Anterior Segment,
and Refractive Surgery

100 N. Wiget Lane, Suite 270
Walnut Creek, CA 94598
T: 925 705 7299

- Cataract surgery with the latest lens implants
- Laser cataract surgery
- Refractive Surgery (LASIK, PRK)
- Corneal disease and corneal transplantation
- Comprehensive eye examinations
- Treatment for dry eyes
- Diagnosis and treatment of glaucoma

Thanks to the marvels of the internet and e-mail, we are able to help you save time at your next appointment with Eye Care of East Bay. Enclosed are the necessary forms for your upcoming appointment.

We advocate regular medical examinations to safeguard the health of your eyes. New diagnostic and treatment techniques allow us to detect abnormalities early so that successful treatment can be initiated. Our initial examinations are very thorough, so allow two hours for your appointment for a dilated examination. Please bring your eye wear and a list of all of your eye drops and oral medications, including over-the-counter medications and supplements.

Hours & Scheduling

The doctors of the Eye Care of East Bay see patients, by appointment only, Monday through Saturday. If you are not able to keep your appointment, please give us 24 hours notice. We bill \$50.00-\$200.00 for appointments that are missed without notice. If you are running late, please call the office as soon as possible so that we may attempt to accommodate your needs.

What to Expect

The length of your appointment can vary based on the severity and complexity of your eye condition. As we are a referral practice, frequent and unpredictable emergencies are sent to us for our immediate attention, and our appointment schedule, at times, may be delayed. Depending on what you're being examined for, both of your eyes may be dilated and this can affect your ability to drive. It is recommended that you arrange for transportation to and from our office.

KNOW YOUR INSURANCE

There are hundreds of different insurance plans. They are sometimes complex and difficult to understand. We take many insurance plans. It is to your advantage and your responsibility to know your insurance.

Who is my PCP?

Your "PCP" is your Primary Care Physician. We are your "Specialist" Physicians. If you have an HMO or POS plan (indicated on your insurance card) you will need to select a PCP. Some PPO and EPO plans also require PCP's and doctors within your network.

Which Providers can I see on my insurance plan?

If you have an HMO plan, please check which "Medical Group" you are assigned. This is usually found on the front of your insurance card near your PCP's name. An "IPA" is another system that your insurance assigns to you in place of a "Medical Group". The function is the same.

Each HMO insurance plan assigns its patients to a particular Medical Group or IPA. Individually, all of your Providers including Specialists must be contracted with your assigned Medical Group. Your PCP should be able to select the Specialists that you are eligible to visit. Your PCP also provides you with an "Authorization" to receive care from a Specialist. Since we are a Specialist office, you will need to have an Authorization for your care with our specialist. It is your responsibility to obtain an authorization from your PCP if you have HMO or POS coverage. Your Specialist is not required to obtain the authorization for your visits.

Please inform our receptionists whenever there is any change in your insurance. This is important to you. If you change insurance and we provide you with service for which we are NOT providers, you are personally responsible for the office visit.

Ask Yourself:

- Do I need an authorization for my upcoming office visit to Eye Care of East Bay?
- Have I recently gotten a new insurance card?
- Is my Medical Group the same?
- Do I need to call my PCP or Insurance Company with any Questions?

Please take a moment and learn about your insurance coverage.

We are concerned about continuing to provide you with the best possible medical eye care possible and your knowledge about your coverage will help us to do our job

Thank you

Please, PRINT, READ, SIGN and DATE ALL FORMS where indicated.

If you have any concerns about a question on these forms, we will be happy to help you when you come in for the appointment.

This Patient Packet contains 14 pages including a Map to our new office. If you would rather fill in these forms in our office, please come to your appointment 30 minutes early and enjoy the marvels of a clipboard.

1st FORM: Patent registration (three pages)

2nd FORM: Financial Policy (two pages)

3rd FORM: Lifetime Beneficiary:

(WE WILL NEED YOUR INSURANCE CARD AT THE TIME OF THE APPOINTMENT. THIS WILL REPLACE THE INFORMATION ON THIS FORM BECAUSE YOU ARE THE BENEFICIARY).

OR

Use the MEDICARE with SUPPLEMENTAL INSURANCE form.

A photocopy will be taken at the time of your appointment

WE CAN NOT SEE YOU WITHOUT YOUR CARDS IN HAND

4th FORM: NOTICE OF PRIVACY PRACTICES (HIPAA).

(This form is yours to keep.)

5th FORM: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA). Please print your name, sign, and date
(This is acknowledging that you received the 4th form)

REMEMBER; bring the completed forms with you. This should save you time on the day of your appointment. We are looking forward to seeing you and please drive safely.

If you need to cancel, for any reason,

WE HAVE A 24 HOUR ADVANCE CANCELLATION NOTICE REQUIREMENT
A MEDICAL SPECIALIST HAS BEEN SCHEDULED TO BE HERE FOR YOUR NEEDS
THUS A \$50.00 MINIMUM OFFICE FEE WILL BE CHARGED
FOR MISSED APPOINTMENTS (\$100.00-\$200.00 fee for multiple appointments
scheduled in the same visit, i.e. testing with your doctor visit, etc.)

Eye Care of East Bay

PATIENT REGISTRATION

PATIENT NAME: _____
(Mr/Mrs/Ms/Miss/Dr/Other _____) LAST FIRST MI SOCIAL SECURITY#

AGE: _____ DATE OF BIRTH: ____/____/____ GENDER: M / F

The following 3 questions are required by the Government:

PREFERRED LANGUAGE _____ RACE: _____ ETHNICITY: _____

ADDRESS: _____

STREET CITY STATE ZIP
HOME PHONE: () CELL PHONE: () WORK PHONE: ()

EMAIL _____

EMPLOYER: _____ OCCUPATION: _____ MAY WE CONTACT YOU AT WORK? Y / N

EMERGENCY CONTACT PERSON: _____ PHONE: ()

IN CASE OF MINOR/DISABLED PERSON PLEASE LIST NAME OF RESPONSIBLE PARTY:

NAME: _____ RELATIONSHIP: _____ PHONE: ()

ADDRESS: _____

STREET CITY STATE ZIP

WHO MAY WE THANK FOR REFERRING YOU? _____

PRIMARY CARE PHYSICIAN: _____ PHONE: ()

OPTOMETRIST/VISION CENTER: _____ PHONE: ()

INSURANCE INFORMATION (ALL INFORMATION BELOW IS REQUIRED IN ORDER TO BILL YOUR INSURANCE, THANK YOU) PRIMARY

INSURANCE COMPANY : _____ HMO GRP NAME (IF APP): _____

SUBSCRIBER NAME: _____ SUBSCRIBER'S ID# and/or SS#: _____

SUBSCRIBER DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE COMPANY : _____ HMO GRP NAME (IF APP): _____

SUBSCRIBER NAME: _____ SUBSCRIBER'S ID# and/or SS#: _____

SUBSCRIBER'S DATE OF BIRTH: / / ____

- Patients are required to present their insurance identification cards at the time of each visit. If your insurance requires a Referral or Authorization, it is your responsibility to notify our office at the time of making your appointment. We bill your insurance as a courtesy for you.
- It is the policy of Eye Care of East Bay to collect all Co-Payments at the time of each service. If a patient does not have proof of insurance, full payment is required at the time of service.

PERSONAL EYE HISTORY (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dry/Watery Eyes | <input type="checkbox"/> Refractive Vision Correction |
| <input type="checkbox"/> Retinal Detachment/Tears | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Retinal Hemorrhages/Bleeding |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Crossed Eyes/Strabismus | <input type="checkbox"/> Retinal Lasers or Surgeries |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Droopy Lids | <input type="checkbox"/> Ocular Migraines |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Traumatic Injuries/Accidents |

Please explain any of the above as well as other history or conditions: _____

List all Eye Drop Medications: _____

PERSONAL MEDICAL HISTORY (Please complete Review of Systems form)

Any other illness not listed (Please Specify): _____

Please list all prescription medications and / or all vitamins and over the counter remedies currently taking. (Please include blood thinners like aspirin and anti-inflammatory agents) _____

Allergies to Medications: Yes _____ No _____ Please List _____

Do you have a Pace Maker/Cardiac Defibrillator? (Please state which) _____

List all surgical procedures/dates: _____

FAMILY HISTORY (Check all that apply and what family member)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Retinal Detachment/Tears _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Diabetic Retinopathy _____ |
| <input type="checkbox"/> Thyroid _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Macular Degeneration _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Diabetes Type I _____ Type II _____/ _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Cancer _____ | |

SOCIAL HISTORY - Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Do you Drink Alcohol? Yes _____ No _____ How Often? _____ Do you use recreational Drugs? Yes _____ No _____ Specify _____

Do you Smoke? Yes _____ No _____ Packs/Day _____ Do you Drive? Yes _____ No _____

Patient's Signature _____ Date _____

Patient's Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas? Please mark Yes (Y) or No (N) for each one.

Cardiovascular	Y	N
Chest Pain		
Irregular Heart Beat		
Shortness of breath		
Stroke		

HEENT	Y	N
Dizziness		
Loss of Hearing/Deaf		
Hoarseness		
ringing in Ears		
Sore Throat		
Recent Viral Infection		
Dryness of Mouth		

Musculoskeletal	Y	N
Back Pain		
Joint Pain		
Muscle or Neck Pain		
Stiffness		
Swelling		
Arthritis		

Respiratory	Y	N
Cough		
Trouble Breathing		
Wheezing		
Chronic Bronchitis		
Chronic Emphysema/COPD		
Asthma		
Sleep Apnea		

Blood Pressure Control	Y	N
Borderline BP control		
Good BP Control		
Poor BP Control		
Unknown BP Control		

Constitutional	Y	N
Fatigue/Tire Easily		
Fever		
Night Sweats		
Weakness		
Weight Loss		

Blood-Hematologic	Y	N
Bleeding Disorder		
Bruising		
Tender Nodes		
Anemia		
Hepatitis _____		

Neurological	Y	N
Balance Problems		
Headaches		
Numbness		
Tingling		
Seizures		
Multiple Sclerosis		

Integumentary (Skin)	Y	N
Hair Loss		
Rashes/Facial Acne		
Skin Lesions		
Rosacea		
Shingles		
Herpes		

Diabetes	Y	N
Borderline DM Control		
Good Dm Control		
Poor DM Control		
Unknown DM Control		
Diabetes Type I/Type II		

Genitourinary	Y	N
Genital Discharge		
Genital Sores		
Painful Urination		
Urgency		

Metabolic	Y	N
Cold Intolerance		
Excessive Hunger		
Frequent Urination		
Heat Intolerance		
Grave's Disease		
Hashimoto's Disease		
Thyroid Hyper_Hypo_		

Psychiatric	Y	N
Anxiety		
Depression		
Insomnia		
Irritability		
Nervousness		

Allergic-Immunologic	Y	N
Chronic Runny Nose		
Hives		
Itching		
Hay Fever Symptoms		
Skin or Respiratory		
Lupus		
Rheumatoid Arthritis		

Pregnancy	Y	N
First Trimester		
Second Trimester		
Third Trimester		

Eyes	Y	N
Burning		
Crossed Eyes		
Distorted Vision		
Double Vision		
Dryness of Eyes		

Eyes (Continued)	Y	N
Excess Tearing		
Eye Pain or Soreness		
Flashing Lights		
Floating Objects		

Eyes (Continued)	Y	N
Glare/Light Sensitive		
Itching		
Lazy Eye (Amblyopia)		
Loss of Vision		
Redness		

Eyes (Continued)	Y	N
Past Eye Surgery		
1.		
2.		
3.		
4.		
5.		

Past Medical Surgery	Y	N
Type of Surgery		
1.		
2.		
3.		
4.		
5.		

REVIEWED / PERFORMED / UPDATED _____ M.D. / O.D. DATE: _____

Eye Care of East Bay

FINANCIAL POLICY

PATIENTS WITHOUT INSURANCE

Our fees cannot always be determined in advance, since they depend on services rendered.
FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

PATIENTS WITH INSURANCE

We require you to show your current insurance cards at each visit.

Although we bill your insurance company or Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan or Medical Group, we will contact you for assistance. Should your health plan or Medical Group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

MEDICARE

We will bill Medicare, secondary, and tertiary health plans for you. You must, however, supply us with the most up-to-date and correct information at the time of your visit. You will be responsible for your deductible and co-pays. If you do not have a supplemental insurance, or if you do not bring your card, you will be required to pay the 20% that Medicare does not, at the time of your visit.

PRIVATE INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account. If you have a co-pay or deductible, plan to pay it at the time of your visit.

HMO/PPO

CO-PAYMENT AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT. YOU MUST HAVE A CURRENT AUTHORIZATION/REFERRAL AT THE TIME OF YOUR VISIT.

Medi-Cal, State Medi-Cal, CCHP

We are not CCHP or Medi-Cal providers. If you choose to be seen by our Doctors, you will be charged for your examination. Medicare-Medi-Cal patients will be charged the 20% that Medicare does not cover. State Medi-Cal patients are responsible for the entire amount. Payment is required at the time of service. We do not bill Medi-Cal or CCHP

MISSED APPOINTMENTS

I understand that there will be a minimum \$50.00 charge for any missed office appointments without a 24-hour notice. (\$100.00-\$200.00 fee for multiple appointments scheduled in the same visit, i.e. testing with your doctor visit, etc.)

SURGERY CANCELLATION FEES

There is a \$300.00 cancellation fee if you have to cancel or reschedule your surgery. This fee is waived if your physician for medical reasons cancels the surgery. Scheduling surgery is extremely time consuming, therefore we ask that you are sure of your dates prior to committing to them.

LATE FEES

There will be an additional 10% charged for unpaid balances after 60 days and an additional 15% after 90 days. After 120 days the balance will go to collections. These charges are enforced after payments from insurance.

FORM FEES

Due to the large number of forms received by our office we have been forced to charge for their completion. An example of charges is listed below.

FORMS	FEE
Private or Miscellaneous forms, (including DMV forms)	\$25.00
Specialty letters per patient request.....	\$35.00
(Grievance, appeals or letters of medical necessity)	

Copies of testing.....Black & White \$10.00,...Color \$35.00

*Fees for copies of your records are found in the HIPAA Policy. This includes sending copies to other doctors.

RE-BILLING FEES

If we are not provided with the most current insurance information, and we have to re-bill, there will be an additional \$20.00 charge.

We accept checks and most major credit cards

Thank you for understanding our financial policy.

Please let us know if you have any questions or concerns.

I, THE UNDER SIGNED, HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Responsible Party: _____ Date: _____

Patient's Name Printed: _____

Eye Care of East Bay

Vahid Feiz, MD
100 N. Wiget Lane, Suite 270
Walnut Creek, CA 94598 T: 925 705 7299

MEDICARE EXTENDED AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

“Signature on File”

Beneficiary Name (Patient)

Medicare Health Insurance (HIC)

I request that payment of authorized Medicare benefits be made on my behalf to Eye Care of East Bay for any services furnished to me by Eye Care of East Bay. I authorize any holder of medical information about me, in order to determine these benefits or benefits payable for related services, to be released to the Health Care Financing Administration and its agents.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, Eye Care of East Bay agrees to accept the charge determination of the carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the carrier.

Patient Signature

Date

MEDI-GAP (SECONDARY INSURANCE) ASSIGNMENT OF BENEFITS

I understand that if I have a Medi-Gap (Secondary Insurance) policy or other health insurance, my signature authorizes release of the information to the insurer or agency.

I request that payment of authorized Medi-Gap (Secondary Insurance) benefits be made on my behalf to Eye Care of East Bay for any services furnished to me by my physician.

Patient Signature

Date

REV7-28-15

REV 1-02-15v10

Eye Care of East Bay

Vahid Feiz, MD
100 N. Wiget Lane, Suite 270
Walnut Creek, CA 94598 T: 925 705 7299

COMMERCIAL INSURANCE ASSIGNMENT OF BENEFITS AUTHORIZATION

Beneficiary (Patient's name)

I request that payment of authorized _____ (and)
(Name of Insurance Carrier)

(Secondary Insurance if applicable): _____ benefits
(Name of Secondary Insurance Carrier)

Be made on my behalf to Eye Care of East Bay for services furnished me by Eye Care or East Bay.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, Eye Care of East Bay agrees to accept the charge determination of the carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the carrier.

Beneficiary Signature

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 23, 2013, and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Deborah Valentine, COT, OSA. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$0.50 for each page and the staff time charged will be \$20.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

HIPAA Notice of Privacy Practices 2013

This form does not constitute legal advice and covers only federal, not state law.

OmnibusRule

National Security: **The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.**

Abuse or Neglect: **We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.**

Public Health Responsibilities: **We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.**

Marketing Health-Related Services: **We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.**

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: **We may use your health records to remind you of recommended services, treatment or scheduled appointments.**

Access: **Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$0.50 for each page and the staff time charged will be \$20.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.**

Amendment: **You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.**

Breach Notification Requirements: **It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.**

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Practice Name:

Eye Care of East Bay

100 N. Wiget Lane, Suite 270

Walnut Creek, CA 94598 T: 925 705 7299

HIPAA Notice of Privacy Practices 2013

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OmnibusRule

Eye Care of East Bay
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here
Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date

DIRECTIONS TO OUR OFFICE

Coming from San Francisco

Take I-80 E and CA-24 E to Ygnacio Valley Rd in Walnut Creek. Take the I-680 N exit
Keep right to continue on Exit 15B
Follow signs for Ygnacio Valley Rd.

Follow Ygnacio Valley Rd to N. Wiget Ln
Use the right 2 lanes to turn right onto Ygnacio Valley Rd
Use the 2nd from the left lane to Turn left onto N. Wiget Ln.

Coming from Livermore, Dublin, Hayward

Go 680 North Take Exit 15B,
Follow signs for Ygnacio Valley Rd.

Follow Ygnacio Valley Rd to N. Wiget Ln.
Use the right 2 lanes to turn right onto Ygnacio Valley Rd
Use the 2nd from the left lane to Turn left onto N. Wiget Ln.

