

Notice of Privacy Practices

Professional Eye Associates

9 Fork Street, Mt. Pocono, PA 18344/HC#2 Box 1702, BK Plaza, Brodheadsville, PA 18322

570-839-2221/570-992-3933

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IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that you might identify private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for payment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines voice mails, or emails; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions, and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for continued care.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payers in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDED PERMISSION

In some other limited situations, the law allows us to use or disclosed your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime.
- Disclosure for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings.
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ and tissue donations
- Disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information.
- Disclosures related to a workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures.

Acknowledgement of Notice of Privacy Practices

The law requires that Professional Eye Associates make every effort to inform you, the patient, of your rights related to your personal health information (PHI). By my signing below, I acknowledge that:

*****PLEASE CHECK ONLY ONE BOX BELOW*****

Yes, **I have read** or had explained to me Professional Eye Associates Notice of Privacy Practice and **I agree** to continue my care with Professional Eye Associates under said terms.

No, **I have NOT** read Professional Eye Associates Notice of Privacy Practice but, **I was given the opportunity to read it upfront and declined** but with to continue my care with Professional Eye Associates under the terms of Professional Eye Associate's privacy policies.

Yes, I have read or had explained to me Professional Eye Associates Notice of Privacy Practice and **I DO NOT wish to continue my care** with Professional Eye Associates under said terms.

Only check this box if Patient does not speak the English Language and does not have an interpreter

The Noticed of Privacy Practice **could not be read** due to the emergent nature of the care of **other reasons** described below as

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name

Date

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative Name

Relationship to Patient

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