Columbus Eye Associates & Columbus Optical

PATIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____
First Middle Last

HOME PHONE: _____ CELL PHONE:_____WORK PHONE:_____

EMAIL ADDRESS:_____

PHYSICAL ADDRESS:_____APT#_____

CITY, STATE:_____ZIP:_____

MAILING ADDRESS (if different than Physical Address):_____

CITY, STATE:_____ZIP:_____

SOCIAL SECURITY NUMBER:_____ PATIENT GENDER: Male or Female

MARITAL STATUS: Single Married Widowed Divorced Separated

PATIENT'S OCCUPATION:_____EMPLOYER:_____

**IS THE REASON FOR YOUR VISIT WITH US TODAY A JOB RELATED INJURY? YES or NO? IF YES, PLEASE INFORM THE FRONT DESK SO THEY CAN GET THE REQUIRED INFORMATION FROM YOUR PLACE OF EMPLOYMENT TO EITHER FILE WITH WORKER'S COMP OR TO INSURE PAYMENT FROM YOUR EMPLOYER.

EMERGENCY CONTACT NAME:_____RELATIONSHIP TO PATIENT:_____

HOME PHONE: _____ CELL PHONE:_____ WORK PHONE:_____

HOW DID YOU HEAR OF OUR CLINIC?:_____

BILLING INFORMATION (Insurance policy holder or Person responsible for payment)

NAME:_____ DATE OF BIRTH:_____

RELATIONSHIP TO PATIENT:_____ SOCIAL SECURITY NUMBER:_____

ADDRESS:_____ APT#_____

CITY, STATE:_____ ZIP:_____

PATIENT SIGNATURE: _____ **Date**: _____

IF ABOVE NAMED PATIENT IS A MINOR …

_____
Print Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

IF PARENT OR GUARDIAN IS NOT PRESENT AT TIME OF SERVICE …

_____
Print Name of Representative of Parent or Guardian

_____ _____
Signature of Representative of Parent or Guardian Date

COLUMBUS EYE ASSOCIATES MEDICAL INFORMATION SHEET (PLEASE COMPLETE ENTIRE FORM)

Patient Name: _____ Today's Date: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Primary Care Physician: _____Phone #_____

Referring Doctor/Clinic: _____Phone # _____

Check any **ACTIVE** medical conditions that apply to you:

___Diabetes or Pre-Diabetes. If you are diabetic or pre-diabetic, what is your last known HgA1C? _____ Last BS reading? _____

___High Cholesterol	___Multiple Sclerosis	___Cataracts	___HIV/AIDS
___Thyroid Disease	___Heart Disease	___Glaucoma	___Shingles
___High Blood Pressure	___Asthma	___Macular Degeneration	___Hepatitis
___Low Blood Pressure	___Sjogrens	___Migraines	___ Meningitis
___Rheumatoid Arthritis	___Lupus	___Bells's Palsy	___Cancer (type/stage):_____

___OTHER: _____

***FEMALES ONLY:** Are you currently pregnant? ___YES or ___NO. If yes, due date? _____
Are you currently nursing? ___YES or ___NO

Have you ever had trauma to your head or eye(s)? ___YES or ___NO. If yes, please explain below:

_____

List any previous surgeries, including eye surgery **AND** any recent hospitalizations: _____ _____

_____ _____ _____ _____ _____ _____

***Have you ever taken Flomax (tamsulosin), Hytrin, or any bladder intolerance medications? ___YES or ___NO?**
These medications may cause an issue with the dilation process of the pupils, even if you are no longer taking them

Family History: Does anyone in your family have a history of medical problems? (if so, please explain)

Mother:_____Father:_____
Sibling(s):_____Children:_____
Maternal Grandparent(s)_____Paternal Grandparent(s)_____

List any medications that you have had an **allergic reaction** to: _____ _____ _____ _____

List all of your current medications, over-the-counter medications, vitamins, supplements **AND** eye drops below:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Local Pharmacy: _____Address:_____ Phone #_____

Mail-Order Pharmacy: _____Phone #_____

Are you a current smoker? ____YES or ___NO. If no, are you a former smoker? ____YES or ___NO
Do you consume alcohol? ___YES or ___NO. If so, how often? ____Daily ___Social Occasions ___Rare

If you are having a problem today with your eyes or vision, specify problem on the lines provided below and/or check from the following:

_____

_____

____ Visual loss, sudden/gradual	____Floaters	____Matter/Discharge	___Burning
____ Blurred vision	____Flashes of light	____Watering/Tearing	___Redness
____ Double Vision	____Pain and/or irritation	____Itching	___Dryness

Columbus Eye Associates
CANCELLATION / MISSED APPOINTMENT POLICY

As of 08/01/18

Our goal at Columbus Eye Associates is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of our clinic schedule and the medical needs of other patients, please be courteous and call Columbus Eye Associates promptly if you are unable to attend your appointment for any reason. This allows the time to be reallocated to someone else who is need of treatment that day. **If it is necessary to cancel your scheduled appointment, we require that you call in advance prior to your appointment to cancel.** This includes both new and established patient appointments since appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call any one of our office locations prior to your appointment. You may leave a detailed message on the front desk scheduling voicemail box. If you would like to reschedule your appointment, please be sure to leave us your phone number on the voicemail and we will return your call as soon as possible. **Cancellations received after the appointment time are considered late and documented as a "no-show".**

Missed Appointment Fee Policy

A "no-show" is a missed appointment without notice prior to the appointment. These "no-shows" adversely affect our clinic schedule and inconvenience other patients who may need access to medical care in a timely manner. This includes arriving more than 15 minutes after the time of the scheduled appointment without notice and will be recorded in the patient's chart as a "no-show" (The charge applies even if the patient is able to be accommodated and still be seen by the doctor that day and must be paid at that visit).

These "no-shows" will incur a $30 MISSED APPOINTMENT FEE to be placed on the patient's account and a statement will be billed out to them. This fee is not billable to insurance and must be paid prior to your next appointment without exception.

*** I have read the above policy completely. By sigining below, I understand and agree to all of the terms. ***

PRINT PATIENT'S NAME: _____

Patient's Signature: _____ Date: _____

IF ABOVE NAMED PATIENT IS A MINOR,
Print Patient's Parent/Guardian Name: _____

Patient's Parent/Guardian Signature: _____ Date: _____

COLUMBUS EYE ASSOCIATES & COLUMBUS OPTICAL
FINANCIAL/TREATMENT POLICY AGREEMENT

As of 04/11/18

CONTACT INFORMATION. I understand that it is my responsibility to provide and keep Columbus Eye Associates and Columbus Optical up to date with my most current mailing address, home phone number, cell phone number, work phone number, and email address. I understand that this is very important so that I may be contacted with regards to my eye care and my optical eye wear needs.

EMAIL ADDRESS. The email address that you provide below will only be used for purposes such as providing you with patient education; in-office professional notices such as appointment reminders and recalls; newsletters; specials on eye exams and optical goods and services. My Primary Email is _____

REFRACTION. One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. Refraction refers to how light waves are bent as they pass through your cornea and lens. A refraction assessment helps determine a corrective lens prescription that will give you the sharpest vision. A Doctor or Technician may use a technique called retinoscopy. In this procedure they shine a light into your eye and measure the refractive error by evaluating the movement of the light reflected by your retina. Then they fine-tune this refraction assessment by asking you to look through a Phoroptor, a mask-like device that contains wheels of different lenses and judge which combination gives you the sharpest vision. By repeating this step several times, they are able to find the lenses that give you the greatest possible acuity. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information to have as we assess your eyes and look for problems. I understand that without the refraction my Doctor may not be able to fully assess the health and function of my eyes. I also understand that most insurance plans consider a refraction a "vision" service not a "medical" service, therefore I understand that a refraction is NOT a covered service by Medicare and most other insurance companies and it is my responsibility to pay for the refraction at the time of service. ***The fee for the refraction is $30***. Unless my plan automatically covers the refraction charge, this fee will be collected at the time of service in addition to any co-payment my plan may require. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

CONTACT LENS EVALUATION. I understand that if I am contact lens wearing patient, during my Doctor visit a contact lens evaluation may be performed to check the health of my eyes and to look for adverse effects from contact lens wear. I also understand that this may not be a covered service by Medicare, Medicaid, and most other insurance companies. ***The $20 fee for this service provided by my Columbus Eye Associates Doctor is my responsibility to pay for at the time of service.*** I also understand that there may be a separate dispensing fee charged by Columbus Optical that may be my responsibility. Why is there a contact lens evaluation fee in addition to the standard eye exam fee? Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. In order to renew your contact lens prescription, your Doctor may need to perform tests that are not part of a standard eye exam on a yearly basis. The tests that they may perform are:

- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues.
- Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions).
- Review new lens designs and materials that may improve comfort and/or health.
- Corneal topography, a digital color map of the surface of the cornea to monitor shape and curvature, which may be affected by contact lens wear.

<u> PARTICIPATING PROVIDER and PARTICIPATING FACILITY LOCATION **</u>**

I understand it is my responsibility to determine if the ***Doctor*** that I receive services from at the ***facility location*** where I received the services at is a participating provider on my network for my insurance. ***I understand that if my insurance plan (HMO, Healthselect, etc) requires referral authorization through my primary care provider directly from the insurance it is my responsibility to request this for my visit(s) to be covered by my insurance.*** It is also my responsibility to always provide the most current copy of my insurance card at each visit. I hereby authorize any insurance company to pay the proceeds of any benefits due me, directly to Columbus Eye Associates and/or Columbus Optical. I also authorize Columbus Eye Associates and/or Columbus Optical to release any information necessary to process this assignment of claim. I understand that Columbus Eye Associates and/or Columbus Optical are obligated to submit my claim information to my insurance company if they are under contract with them.

<u>EXAM CONSENT and FINANCIAL RESPONSIBILITY.</u> I consent to examination and/or treatment of myself or as parent/guardian of the patient named on this form. I acknowledge and understand that I am responsible for all charges for all services rendered to me. Although I may have requested that my Doctor bill my insurance company, I understand that it is my responsibility to make sure that the bill is paid. I understand that if I have Medicare, Medicaid and/or any other insurance company I am financially responsible for payment of exams and/or optical goods that are not a covered benefit.

FORM CHARGES. I understand that there may be a *form charge* for filling out extra forms for insurance companies. If the form is required by a health insurance company or by a state or federal agency for disability etc., I will not be responsible for a *form charge*. However, if the form is for personal use and not associated with an examination, or if it is a life insurance form, or personal disability form, I understand that I will be responsible for the $10 *form charge* per form.

DILATION DROPS. I understand that dilating drops are used to dilate or enlarge the pupils of my eyes to allow the Doctors to get a better view of the inside of my eyes. I understand that dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. I also understand that it is not possible for the Doctors and staff at Columbus Eye Associates to predict how much my vision will be affected. Because driving may be difficult immediately after my examination, I understand that it is best if I make arrangements not to drive myself. I understand that adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops and that this is extremely rare and is treatable with immediate medical attention. I understand that the eye drops used to dilate or enlarge the pupils of my eyes may be necessary to diagnose my condition; therefore I authorize the Doctors and/or Staff at Columbus Eye Associates to administer dilating eye drops whenever my eyes are examined unless I decline to be dilated.

**** ROUTINE VISION SERVICES VS MEDICAL VISION SERVICES ****

I understand that routine vision services (such as annual eye exams, contact lens exams, contact lens evaluations, frames, lenses, and/or contact lenses, etc) are payable at the time of service, unless there is a vision benefit available on my insurance plan. I also understand that for my eye exams to be a "routine eye exam" I cannot present with any complaint, problem or diagnosis except those relating to receiving a glasses or contact lens prescription (such as nearsightedness, farsightedness, etc).

I understand that if I have been referred to the doctors at Columbus Eye Associates by another doctor for a medical diagnosis, have been previously diagnosed with a medical diagnosis, or during my evaluation the doctor documents a medical diagnosis which might affect the health of my eyes (such as dry eyes, diabetes, hypertension, cataracts, glaucoma, etc) then my eye exams will be considered a medical eye exam not a routine eye exam. I understand that Routine Eye Exams are billable to Vision Insurance Plans, and Medical Eye Exams are billable to Medical Health Insurance Plans.

If I do not have a routine vision insurance plan, I agree to make full payment for my eye exams and optical goods order at the time I place my order. If I have a routine vision insurance plan, I agree to make full payment at the time I receive my eye exams and when I place my optical goods order *for any amount that is considered my responsibility by my vision insurance plan*. If I have a vision benefit available on my vision insurance plan I authorize Columbus Eye Associates and Columbus Optical Company, and their associated Doctors to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my vision insurance plan be made directly to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors. I agree to assume responsibility for full payment for any amount that is not covered by my vision insurance plan. I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors cannot guarantee what my vision insurance plan benefits are until my vision insurance plan has processed my claim. As a result, I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors are not responsible for determining what my vision insurance plan benefits are. I understand that it is my responsibility to determine if Columbus Eye Associates and Columbus Optical Company, and their associated Doctors and the facility location where I receive my services or goods are a participating provider on my vision insurance plan and that it is my responsibility to provide to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors my most current copy of my vision insurance card. I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors may be obligated to submit my claim information to my vision insurance plan if they have an agreement with my vision insurance plan. I certify that the information that I have provided to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors with regard to my coverage is correct. I further authorize Columbus Eye Associates and Columbus Optical Company, and their associated Doctors to release to my vision insurance plan and its agents any information related to this or any related claim.

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable Interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented In the Medicare Beneficiaries Complaint Log, and completed forms will include the patient's name, address, telephone number, a summary of the complaint, the date it was received, the name of' the person receiving he complaint, and a summary of action taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is not satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company. The patient will be informed of this complaint resolution protocol at the times of set-up of service.

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PRIOR TO FUTURE APPOINTMENTS THE PATIENT WILL RECEIVE A REMINDER BY TEXT MESSAGE,

THE PREFERRED CELL PHONE NUMBER IS (_____)_____-_____ ☐ **I have chosen to decline this option.**

PRINT PATIENT'S NAME: _____

Patient's Signature: _____ Date: _____

IF ABOVE NAMED PATIENT IS A MINOR,
Print Patient's Parent/Guardian Name: _____

Patient's Parent/Guardian Signature: _____ Date: _____

COLUMBUS EYE ASSOCIATES

Quality Eye Care Since 1953

Your Source for…
Comprehensive Eye Care
Fashionable Eye Wear

Todd Hovis, M.D. * Lori Learned, M.D. * Arun Nayar, M.D. * John Wooten, M.D. * Nicole Noska, O.D. * Keith Bourgeois, M.D. * John Miller, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Columbus Eye Associates and Columbus Optical Notice of Privacy Practices with the effective date of May 10, 2017.

_____
Name of Patient

_____ _____
Signature of Patient/Patient Representative Date

_____
If Patient Representative, Relationship to Patient

Columbus Office
100 Sweetbriar Dr
Columbus, Texas 78934
979-732-5771 – Telephone
979-732-6922 – Fax
800-460-EYES (3937) - Toll Free

Methodist West Office
18300 Katy Freeway Ste 415
Houston, Texas 77094
281-829-EYES (3937) – Telephone
281-829-0599 – Fax

La Grange Office
124 N. Washington
La Grange, Texas 78945
979-968-3953 – Telephone
979-968-3435 – Fax

Sealy Office
2879 Hwy 36 South
Sealy, Texas 77474
979-885-0665 - Telephone
979-885-4110 – Fax

www.ColumbusEye.org

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 REVIEW IT CAREFULLY.

We at Columbus Eye Associates and Columbus Optical value our relationship with you, and we take your personal privacy seriously. Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff as well as other associated individuals or entities that will be following this notice. This notice applies to all of these individuals, entities, associated with Columbus Eye Associates and Columbus Optical at all of their locations located in Texas. In addition, these individuals, entities, and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Demographic and contact information such as your name, address, home phone number, cell phone number, primary email, secondary email, social security number, date of birth, etc..
- Information relating to your medical history.
- Information relating to your insurance and coverage.
- Information concerning your doctor, nurse or other medical providers.
- Information relating to your glasses or contact lenses.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care"- such as the referring physician, your other doctors, your health plan, and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the

eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you, which are described below.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies, which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit use to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or

illnesses without regard to fault.

Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We also may release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" -- such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information in order to contact you about an appointment, or that you should schedule an appointment, or that your glasses or contact lenses are ready.

Treatment Alternatives. We may use and disclose your personal health information in order to contact you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.

To exercise any of your rights, please contact Stacie Sims in writing at 100 Sweetbriar, Columbus, Texas, 78934.

When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov).
You also may contact Stacie Sims at Columbus Eye Associates & Columbus Optical, at 100 Sweetbriar, Columbus, Texas 78934.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our Privacy Officer, Stacie Sims at Columbus Eye Associates & Columbus Optical, 100 Sweetbriar, Columbus, Texas 78934.

This notice is effective as of May 10, 2017.