FRANKLIN SQUARE EYE CARE
918 HEMPSTEAD TPKE
FRANKLIN SQUARE, NY 11010
TEL #: (516) 354-4242
FAX #: (516) 354-7788
E-mail: franklineyecare@gmail.com
OFFICE CONTACT PERSON: SHERIN GEORGE O.D.

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.

GENERAL RULE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices.

Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission. Sometimes the written permission will be called a consent form, and sometimes it will be called an authorization form. The type of permission form will depend upon the kinds of uses or disclosures that are involved. In some limited situations, the law allows or requires us to disclose your health information without either a written consent or authorization.

USES OR DISCLOSURES WITH CONSENT

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations of this office. We are allowed to refuse to treat you if you do not sign the consent form.

We use information for treatment purposes, when, for example, we set up an appointment for you, when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when the doctor prescribes medication, when our staff helps you select and order glasses or contact lenses, when our staff helps you select and order glasses or contact lenses, vision therapy, and when we show you low vision aids. We may disclose your health information outside of our office for treatment purposes if, for example, we refer you to another doctor or clinic for eye care or low vision aids or services, if we send a prescription for glasses or contacts to another to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

We use your health information for payment purposes when, for example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health or vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due.

We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for health care operations in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, for fundraising activities, and for outside storage of our records.

USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures relating to worker's compensation programs;
- disclosures to business associates who perform health care operations for us and who agree to keep your health information private.

APPOINTMENT REMINDERS

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and / or leave a reminder message on your home answering machine or with someone who answers your phone, if you are not home.

OTHER DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form. If you do not sign the authorization, we cannot make the use of the disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written

request to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request, no matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written notice to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site (www.optometry.osu.edu).

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to our HIPAA Privacy Officer, at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call HIPAA Compliance Officer, at the address or phone number shown at the beginning of this Notice.

PAYMENT AND INSURANCE OPTIONS

Helping you receive your maximum allowable benefits and avoid any financial misunderstandings in the future is our goal. For us to achieve this goal, it is your responsibility to understand your insurance coverage and our payment policies. As you are responsible for charges not covered by your insurance plan, we suggest that you verify your eligibility for services prior to your visit.

Fees and Payment Policies **We accept cash, checks, debit cards and MasterCard, and Visa**

• **Full payment for our services is due at the time the services are rendered**. **We "Accept Assignment" from the insurance plans in which we participate. "Accept Assignment" still requires you to pay all co-payments, coinsurances, deductibles and non-covered services.**

• **Refraction (the determination of your eyeglass prescription) may not be a covered service. Many insurance carriers including Medicare select not to cover this procedure. A refraction is a test that measures your best possible vision. During the test, lenses are placed in front of your eyes and the patient is asked, "which is better—one or two?" A refraction is a separate procedure that measures your ability to see and determine if you need new glasses or if you need a change in your current glasses. It will also determine if you need bifocals. It is typically performed during both a routine exam as well as part of an evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma, dry eye or macular degeneration. We charge patients $30 for this procedure if your insurance does not cover this procedure.**

• **Contact lens fitting and/or evaluation are not part of a routine examination. Your insurance may not pay for this service. There may be a separate fee depending upon your individual insurance coverage.**

• **If your managed care plan requires a referral, that referral must be obtained prior to services being rendered. Otherwise, you will be responsible for payment. We request that you provide us with your complete insurance information at the time of your initial visit.**

• **Returned checks are subject to a $30 fee. Balances owed after 90 days may incur a billing fee as well as an administrative fee until balances are paid in full. If your account goes into collection you are responsible for the original charges and any expenses this office or the collection agency incurs collecting them.**

• **A 50% deposit is required on all materials including eyeglasses, contact lenses and low vision devices.**

• **Your company may offer a medical spending account, which allows you to set aside pre-tax dollars to pay for your medical expenses. Please contact your employer for more details.**

Frequently Asked Questions

What is the difference between routine eye examinations and a visit for medical care? Your visit for routine eye care allows your eye doctor to evaluate your visual needs. The doctor can determine if there is a need to prescribe or change your prescription for vision correction. It also allows him/her to evaluate your eye health, to rule out the most common eye diseases and to determine if there is a need for further evaluation and procedures.

What is vision Insurance and how does it differ from medical insurance? Vision insurance is usually a separate insurance covered by your employer or insurance company that covers routine eye care and may or may not include payments towards eyeglasses or contact lenses. It cannot be used to treat medical problems. Medical eye care involves visits and procedures your doctor performs to diagnose and to treat eye disease such as glaucoma, dry eye, conjunctivitis and cataracts. It may or may not include determination of your eyeglass prescription.

Does my medical insurance cover routine eye care? Typically, your major medical insurance or managed care

plan pays for procedures needed to diagnose and treat eye disease. While the examination may provide you with a new eyeglass prescription, medical insurance rarely pays for routine care and refractions.

Does insurance cover refractions? Many of the examinations and tests performed at Franklin Square Eye Care evaluate your eyes for possible disease. Once a disease is found, examinations and tests allow us to manage your eyes appropriately. There is however, one test called a refraction that is typically not covered by insurance that needs to performed at least once a year. It is not an optional test, but essential to fully evaluate your eyes appropriately.

Federal guidelines state that the office visit and the refraction are to be reported as two separate charges when submitting your services to Medicare and other insurances. Most medical insurance carriers do not cover charges for the refraction and there is a separate charge for this service. The payment for the refraction must be made at the time of service along with your copay and any deductible amounts for the covered charges for your visit.

Contact Lens Warning

Contact lenses are medical devices. Improper use may endanger your eyes. Your eyes may change with time and contact lenses that were initially fitting properly may no longer be appropriate. Visit your eye doctor periodically to ensure correct fitting of your lenses. Remember to discontinue lens wear and call your doctor if you experience any signs of complications including pain, redness, irritation or loss of vision.

FRANKLIN SQUARE EYE CARE
918 HEMPSTEAD TPKE
FRANKLIN SQUARE, NY 11010
TEL #: (516) 354-4242
FAX #: (516) 354-7788
E-mail: franklineyecare@gmail.com

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by Franklin Square Eye Care and how I may obtain access to and control this information.
Signature of Patient/Relative/Legal Guardian
_____Date____/____/____.
If relative or legal guardian signs, indicate relationship to patient:
_____

SIGNATURE ON FILE / PAYMENT AUTHORIZATION

I request that payment for all services rendered by this facility be made on my behalf to Franklin Square Eye Care. I authorize Franklin Square Eye Care to release to the Centers for Medicare and Medicaid (CMS) and its agents or any other insurer any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that my signature will serve as a lifetime authorization for the release of medical information necessary to pay the claim. If another insurer is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.
I also understand that:

- If my insurance company requires a referral/authorization which is not available at the time of service, I will be financially responsible for the entire charge for the services rendered.
- I am responsible for all charges not covered by my insurance benefits, including the refraction charge.
- I have been given a copy of Franklin Square Eye Care's insurance and payment policies and agree to abide by these policies.

Signature of Patient/Relative/Legal Guardian

_____Date_____/_____/____.

PAYMENT AND INSURANCE OPTIONS

By signing below, I acknowledge that I have been provided a copy of the "payment and Insurance options" and I understand the policies and options described.

Signature of Patient / Relative / Legal Guardian

_____Date____/____/____.