ZELENAK EYE INSTITUTE

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PRACTICE POLICIES

Welcome to the Zelenak Eye Institute! We strive to provide you the highest quality medical care. In order to foster a collaborative relationship, we ask that you accept some responsibilities as well. Please read the following policies and acknowledge your understanding by signing below.

- All co-payments, deductibles, and other fees are due at the time of your visit.
- We accept cash, checks, Mastercard, Visa, and American Express.
- Be aware that Medicare and many other medical insurance plans DO NOT cover preventative or vision (referring to a solely glasses or contact lens examination) related eye examinations. In such cases, you are solely responsible for payment.
- We reserve the right to not make a follow up appointment to see the physician unless your balance has been paid or we have reached a payment plan agreement.

INSURANCE AUTHORIZATIONS AND REFERRALS

- As a courtesy, we will assist you with obtaining authorizations for your examinations or for surgery. However, you are ultimately responsible for ensuring that your visit is authorized and your insurance is active prior to your appointment.
- If an authorization is not obtained, you must recognize that you will be held financially responsible for all costs, or your appointment or surgery may be cancelled.
- The office WILL NOT retro-authorize visits after the appointment time.
- If you have an HMO plan and require a referral or authorization, please call your insurance or primary care doctor before your appointment to verify if the referral has been processed. This includes all new patients consults/exams, follow-up appointments, and surgical procedures.
- If you have a PPO plan, your insurance will be billed as courtesy. You are solely responsible for any non-covered services, deductibles, or co-insurance amounts.
- Please notify us at least 24 hours in advance if you need to cancel or change your appointment time.
- If we know at least 24 hours ahead of time that you will not make your appointment, then we will be able to accommodate another patient in your time slot.
- Failure to give us 24-hour notice will result in a $50.00 fee charged to your account. You will not be able to make another appointment until that balance has been paid in full.
- While we attempt to confirm your appointment prior to your scheduled date, it is your responsibility to remember your appointment time and date.
- Three repeated missed appointments or late cancellations will automatically result in termination of our relationship with you.
- If you are more than 15 minutes late to your appointment, you may be rescheduled.
- If you have an outstanding balance, you must make a payment at the time of your visit.
- We ask that you make a payment on your outstanding balance at each visit.
- We cannot schedule further care in our office if you do not make payments on your bill.
- There is a fee to complete forms – including DMV, disability forms, or letter.
- Please inform the office staff if you need forms filled out when you arrive, or by phone when you schedule your appointment. The fee for completing paperwork is $35.

NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep private any health information that identifies you. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.
By law, we must abide by the terms of the Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by the 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 to our website. This notice applies to all paper as well as electronic (Electronic Medical Record) forms of protected health information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we used or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care, low vision aids, or other services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we disclose the health information for payment purposes are: asking you about your health or vision insurance plans or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or via a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we must do in order to run our office. Examples of how we use or disclose your health information for health care operations are financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use health information inside our offices for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES WITHOUT PERMISSION

In some limited situations, law allows or requires us to 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 include:

- When 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 notice to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, human trafficking, 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 violation 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 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 deceased 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 and disclosures to prevent a serious threat to health or safety;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to you to remind you of scheduled appointments, or to notify you that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that could benefit you.

DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes we may initiate the authorization process if the use or disclosure is needed to continue you proper care or treatment. Sometimes you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form or you may use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make use of the disclosure (unless it falls under one of the aforementioned categories where permission is not required by law). 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 and sent to this office.

While we do have a general office email, we highly recommend that all patients refrain from sending any personal health information since it is not a secure format. We recommend that any protected health information be presented in person or via secure fax at (940) 600-5976.

YOUR RIGHTS REGARDING YOUR 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 this, but if we agree, we must honor the requested restrictions. To ask for a restriction, send a written notice to this office at the address or fax number shown at the top of this notice.

- Ask us to communicate with you in your preferred confidential way, such as by phoning you at home rather than work, by mailing health information to a different address, or by using email. Please note, however, that our clinic email is shared among our office staff and we do not recommend sending protected health information in this format. If you would like to electronically communicate with the doctor, a messaging feature is included in your patient portal.
- Ask us to see or get photocopies of your health information.
- Ask us to amend your health information if you believe it to be incorrect or incomplete. If we agree, we will amend the information within 60 days of your request.
- Get additional paper copies of the Notice of Privacy Practices upon request.

COMPLAINTS

If you feel that we have not properly respected the privacy of your health information, you have the right to file a complaint to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you would like to submit a complaint directly to us, send a written complaint to the office at the address or fax number shown at the top of this notice. If you prefer, you can discuss your complaint in person or via telephone.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures that we have already made in compliance with your prior consent. Zelenak Eye Institute provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

I agree that the doctor(s) at Zelenak Eye Institute may request and use my prescription medication history as well as previous records from other healthcare providers and/or third-party pharmacy benefits payers for treatment purposes.

CONSENT FOR TREATMENT

I authorize the doctor(s) at Zelenak Eye Institute to provide me with medical care consistent with reasonable and current community standards. *If the patient is under 18 years or age, this MUST be signed by a parent or legal guardian.*

DILATING EYE DROPS CONSENT FORM

Dilating drops are used to dilate (or enlarge) the pupils of your eye to allow the Ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies between individuals and may make bright lights more bothersome. It is not possible for your Ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after examination for the reasons stated previously, it is best if you make arrangements for a driver to bring you to your appointment. If you do wish to drive yourself, you may wait at our office, permitting operating hours, until you feel comfortable to drive. If you still feel unsafe to drive

yourself, you may choose a taxi service and leave your vehicle for no more than 24 hours in our parking lot.

Adverse reactions, such as acute angle closure glaucoma, may be triggered by dilating drops. These are EXTREMELY rare and treatable with immediate medical attention.
I hereby authorize the doctor(s) at Zelenak Eye Institute and/or their designated assistants to administer dilating eye drops if necessary for my appointment in order to properly diagnose and treat my eye condition(s).

NON-COVERED SERVICES AND CO-PAYMENT NOTICE

In general, medical insurance coverage is ONLY for medically necessary services. The list below is some of the more common items NOT TYPICALLY COVERED by medical insurances.

- Refraction (to determine your eyeglass or contact lens prescription).
- Most medical insurance plans DO NOT pay for the refraction component of your eye exam. If not covered by your insurance, the COST OF REFRACTION AT OUR OFFICE IS $40.00. We will not bill your medical insurance for this procedure unless you request it. In the rare event that it is covered and reimbursed by your medical insurance, we will gladly refund your $40.00 back to your account and notify you.
- Co-pays and deductibles: These fees are due at the time of service.
- I understand that insurance does not typically cover the items detailed on this page, and that I am personally responsible for payment for these types of services.

FINANCIAL RESPONSIBILITY

I, the undersigned below, request that payment of authorized medical insurance benefits be made on my behalf to Zelenak Eye Institute for services furnished to me by any provider associates with Zelenak Eye Institute. I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information required to determine benefits payable for related services. I understand my signature request that payment be made authorizes release of medical information necessary to pay the claim. My signature authorizes releasing this information to the insurer or agency shown.

If so determined by written contract between Zelenak Eye Institute and my medical insurer, then Zelenak Eye Institute accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of the medical insurance carrier. If no contract exists between Zelenak Eye Institute and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by Zelenak Eye Institute and the charges for the services rendered.

If I represent that I have medical insurance, I accept responsibility for all charges for services furnished to me by Zelenak Eye Institute in the even that it is determined that I was not eligible or authorized to receive such services at the time of service.

If I provide information that is incorrect or invalid, I accept responsibility of all charges for payment for services. I understand that at the time of service, I am responsible for payment in full of any co-pay, out-of-network visit costs, prior outstanding balances, deductibles, and coinsurances. If I do not pay the due balance at this time of service, I agree that a convenience fee of $40.00 will be added to my balance.

If I do not fulfill my financial obligation to Zelenak Eye Institute, I will be sent written invoices detailing my obligation by Zelenak Eye Institute. At the discretion of Zelenak Eye Institute, my account may be referred to a collection agency for failure to clear an outstanding balance. If I am referred to collections, a $100.00 collections fee will be added to my balance due along with any costs (including attorney fees, court costs, and filing fees) necessary to enforce collection of the amount due.

Zelenak Eye Institute accepts cash all major credit cards. Personal checks are accepted from established patients but are never accepted for new patients. If a personal check is returned by the bank for any reason, I will be responsible for a returned check fee of $40.00, which includes the bank's returned check fee as well as office administrative costs for handling the returned check.

Zelenak Eye Institute processes payments using a secure electronic payment system. Zelenak Eye Institute reserves the right to charge the payment on file through the electronic payment system for any outstanding balances for services rendered for which the patient is responsible. We will notify you by telephone and in writing to detail the charges prior to processing. In the event payment cannot be processed due to a card expiring or being cancelled, a $30.00 convenience fee will be added and an updated bill will be sent to you.
I agree that I have read this form, any questions have been answered, and I understand and agree to its content.

Signature:_____ Date:_____