Bedminster Eye and Laser Center, P.A.

WELCOME TO BEDMINSTER EYE!

We would like to take this opportunity to welcome you to our practice and to explain what you can expect on your first visit. Our practice is family oriented with patients ranging from young children to those over 100! The major emphasis in our office is the prevention of visual problems and diseases.

Your initial appointment may include dilation of your pupils. This procedure is necessary in order to determine the health of your eyes. You may experience blurred vision and sensitivity to light for several hours after examination. We, therefore, suggest you bring along a driver, a pair of sunglasses or wait in the office until you feel comfortable with your vision.

If you wear eyeglasses, please bring them with you to your appointment. If you are a contact lens wearer, please wear your lenses to your appointment. You will be asked to remove your lenses after they have been examined on your eyes. Your current eyeglass and/or contact lens prescription information will also be helpful when seen in the office for the first time.

The charge for an Initial Comprehensive Eye Exam is $235.00. If additional tests or procedures are necessary, the procedure and charge will be explained to you at that time (see enclosures). **It is very important that you bring your current insurance cards and a picture ID with you. If you have an HMO or POS insurance plan, it is YOUR responsibility to get a referral from your Primary Care Physician.** Your co-pay is due at the time of service unless prior arrangements have been made. In addition to cash and checks, credit cards [Visa, MasterCard, Discover and American Express] are also accepted.

Your Initial Comprehensive Eye Exam will take approximately 1.5 hours. If you plan on shopping for eyeglasses, expect to spend an additional 45 minutes. In order to expedite your visit, we have attached Registration Forms for you to complete and bring with you on your scheduled appointment date. **IT IS VERY IMPORTANT THAT YOU BRING A LIST OF YOUR CURRENT MEDICATIONS! If you do not have a list, see the attached "My Medication List".** Also enclosed is a notice of our Privacy Policy for you to keep; however, please bring the acknowledgement page with you to your appointment.

Our doctors and staff are looking forward to meeting you and assisting you with your eye care needs.

Sincerely,

Bedminster Eye & Laser Center, P.A.

PATIENT QUESTIONAIRE

Today's Date: _____

Name: _____ Gender: _____ Birth Date: _____ Age:_____

Address: _____ City/State:_____ Zip:_____

Home Phone #: _____ Cell #:_____ Work #:_____

Circle preferred phone for confirming appts. Email Address:_____

Occupation:_____ Employer:_____

Social Security #:_____

Who referred you to our practice? _____

Do you see another eye care provider outside of our office? Y☐N☐

If yes, provide Name: _____

Address:_____ Phone #:_____

Name of Endocrinologist (if applicable):_____

Address:_____ Phone #:_____

Name of Rheumatologist (if applicable):_____

Address:_____ Phone #:_____

Primary Care Physician:

Name:_____

Address:_____

Phone #:_____

Pharmacy:

Name: _____

Address: _____

Phone #:_____

Primary Language: _____

Race: ☑ Native American ☑ Asian ☑ Black ☑ Pacific Islander ☑ White

Ethnicity: ☑ Hispanic ☑ Non-Hispanic

_____ _____

Patient Signature Date

INSURANCE INFORMATION

PRIMARY INSURANCE NAME - _____

INSURANCE ID # _____

SECONDAY INSURANCE NAME - _____

INSURANCE ID # _____

IF SOMEONE OTHER THAN THE PATIENT IS THE INSURED PARTY OR THE "SUBSCRIBER", PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME: _____

INSURED/SUBSCRIBER'S DATE OF BIRTH:_____

PATIENT'S RELATIONSHIP TO INSURED: _____

(E.G. SPOUSE, DEPENDENT, CHILD, OTHER)

PLEASE ALLOW OUR STAFF TO COPY YOUR INSURACE CARDS

GUARANTOR INFORMATION: Please list the person responsible for the bill. Most times this is the patient unless the patient is a child (< 18 years old) or an incapacitated adult.

Patient's Relationship to Guarantor : Self ☐ Spouse ☐ Child ☐ Other ☐

Last Name, First _____

Street Address _____

_____

Phone: _____

**** Employer Name: _____**

Today's Date: _____

Name: _____ Birth Date: _____

Have you ever had any of the following conditions?
(Please check appropriate answers.)

High Blood Press ☐ ☐
Diabetes Y☐N☐ If yes: Type 1 / Type 2
Thyroid Y☐N☐ If yes: hyper / hypo
Arthritis Y☐N☐ If yes: osteo / rheumatoid / other _____
Cancer Y☐N☐ If yes, which type(s): _____
Stroke Y☐N☐
High Cholesterol Y☐N☐
Lupus Y☐N☐
MS Y☐N☐
Heart Disease Y☐N☐
HIV Y☐N☐
Hepatitis Y☐N☐ A ☐ / B ☐ / C ☐
Shingles Y☐N☐
Bell's Palsy Y☐N☐

ANY FAMILY HISTORY OF:

Glaucoma Y☐N☐ Relation:_____
Macular Deg. Y☐N☐ Relation:_____
Cancer Y☐N☐ Relation:_____
High BP Y☐N☐ Relation:_____
Diabetes Y☐N☐ Relation:_____
Other (specify): _____ Relation:_____
_____ Relation:_____

Asthma Y☐N☐
COPD Y☐N☐
Kidney Disease Y☐N☐
Liver Disease Y☐N☐
Crohn's/ Ulcerative Colitis Y☐N☐

Do you currently smoke? Y☐N☐ How much? _____
Have you ever smoked? Y☐N☐ If yes, when did you quit? _____
Do you drink alcohol? Y ☐N☐ How often? _____
Do you use recreational drugs? Y ☐N☐ Which ones?_____
Have you ever had a blood transfusion? ☐ Y ☐ N

Date of last flu shot:_____ Date of last Pneumococcal vaccine :_____

If you are 65 or older have you had 2 or more falls in the last year or any fall with injury in the last year: ☐ Y ☐ N

Please list any other medical and eye conditions for which you have been treated: _____

_____

_____

Please list all major surgeries and any eye surgeries: _____

_____ _____

_____

Please list all allergies (to meds, foods, environs):_____

_____

Patient Signature:_____ Dr. Signature:_____ Date:_____

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Eyes

	YES	NO
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐

Other _____

Ear, Nose, Throat

	YES	NO
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus	☐	☐

Other _____

Cardiovascular

	YES	NO
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐

Other _____

Constitutional

	YES	NO
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Gain/Loss	☐	☐

Other _____

Respiratory

	YES	NO
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

Other _____

Gastrointestinal

	YES	NO
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐

Other _____

Genito-Urinary

	YES	NO
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History of Kidney Stones	☐	☐
History of STDs	☐	☐

Other _____

Psychiatric

	YES	NO
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐

Other _____

Endocrine

	YES	NO
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Increased Urination	☐	☐
Increased Sweating	☐	☐
Fingernail Changes	☐	☐

Other _____

Blood/Lymph Nodes

	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Use	☐	☐

Other _____

Musculoskeletal

	YES	NO
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐

Other _____

Skin

	YES	NO
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

Other _____

Neurological

	YES	NO
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Headaches	☐	☐
Migraines	☐	☐

Other _____

Immunologic

	YES	NO
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐

Other _____

Patient Signature:_____ **Dr. Signature**:_____ **Date:**_____

My Medication List

Name _____ Date _____

	What I'm taking	Form (pill, injection, liquid, patch, etc.)	Dosage	How Much and When	Use (regularly or occasionally)	Start/Stop Dates (1/5/05 - 3/5/05) (1/5/05 - ongoing)	Notes, Directions, Reasons for Use
* Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements.							
1							
2							
3							
4							
5							
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7							
8							
9							
10							
11							
12							

Bedminster Eye and Laser Center, P.A.

LIFETIME Signature of File, Assignment of Benefits, Financial Agreement

_____ _____

Patient Name (print) **SS#**

Initials

_____ **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Bedminster Eye & Laser Center, for services furnished me by Bedminster Eye & Laser Center I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Bedminster Eye & Laser Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ **SECONDARY/SUPPLEMENTAL INSURANCE:** I understand that if a **MediGap policy or other health insurance** is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Bedminster Eye & Laser Center, if possible or otherwise to me. **I understand that I must present proof of secondary insurance on the day of service. If I do not provide proof, I will be responsible for filing a claim with my secondary insurance.**

_____ **COMMERCIAL INSURANCE:** I understand that Bedminster Eye & Laser Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Bedminster Eye & Laser Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Bedminster Eye & Laser Center if I belong to a plan that does not appear on the above mentioned list.

_____ **HEALTH PLAN VS. VISION PLAN:** Most health insurance plans (including Medicare) do not cover routine [non-medical] vision examinations. Some insurers provide coverage for routine vision examinations under their health plan through a special vision benefit or vision rider. **Other insurers may offer such coverage through a separate Vision Plan such as VSP [Vision Service Plan] or EyeMed. Bedminster Eye NOW PARTICIPATES WITH both VSP and EyeMed.** Both plans provide coverage for a WellVision [**routine**] Exam in addition to eyeglasses and contact lenses. **Coverage is NOT provided for medical care. I understand it is my responsibility to know what coverage is available to me.**

VISION INSURANCE MUST BE PRESENTED PRIOR TO VISIT!

_____ **NON-COVERED SERVICES:** I understand that Bedminster Eye & Laser Center's contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Bedminster Eye & Laser Center to obtain necessary health care service plan authorizations.

_____ **REFRACTIONS: I understand most health insurance plans (including Medicare) do not cover the eye refraction test.** I understand that although the refraction may not be covered by insurance, eye refraction is a very important part of a comprehensive eye examination. Refraction charges will be submitted to my insurance carrier for payment. I understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service**. I understand that any co-payment, coinsurance and deductible I may have is separate from and not included in the refraction fee.**

_____ **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Bedminster Eye & Laser Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Bedminster Eye & Laser Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Bedminster Eye & Laser Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Bedminster Eye & Laser Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ **RELEASE OF INFORMATION:** Bedminster Eye & Laser Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Bedminster Eye & Laser Center for
reimbursement for services rendered, and (2) any health care provider for continued patient care. Bedminster Eye & Laser Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

_____ _____

Signature of Patient or Authorized Party Date

PLEASE READ AND INITIAL ALL APPLICABLE STATEMENTS

Bedminster Eye and Laser Center, P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: September 23, 2013

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- Right to an Electronic Copy of Electronic Medical Records. **If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.**

- Right to Get Notice of a Breach. **You have the right to be notified upon a breach of any of your unsecured Protected Health Information.**

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights
To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice
We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints
You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

Late Cancellations/No-Shows
A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **$50.00** missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of **Bedminster Eye & Laser, P.A.'s** HIPAA Notice of Privacy Practices.

Patient Name (Please Print) _____

Patient Signature _____

Date _____

OR

Signature of Personal Representative Authority of Personal Representative to Sign for Patient (check one): □ Parent □ Guardian □ Power of Attorney □ Other:

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgement.

☐ A communication barrier prevented us from obtaining acknowledgement.

☐ The individual was unwilling to sign.

☐ Other:_____

Bedminster Eye and Laser Center, P.A.

Patient Request for Transmission of Protected Health Information To Alternate Address or by Alternate Means

Patient Name: _____ D.O.B. _____/_____/_____

I understand that Bedminster Eye and Laser Center, P.A. (the "Practice") may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. The Practice may disclose my PHI to the following persons acting on my behalf:

1. Name: _____
Address: _____
_____
Phone Number: _____

2. Name: _____
Address: _____
_____
Phone Number: _____

3. Name: _____
Address: _____
_____
Phone Number: _____

I understand that I can request that the Practice send information to me at an alternate address or by alternate means (I.e. via email as opposed to regular mail). Please send information to me at the following address and/or by the following means:

_____

_____

_____

_____

The Practice will agree to this request so long as the information can easily be provided in the manner requested. I understand that if the Practice will incur costs by complying with the request, I will be required to provide payment to the Practice in advance.

_____ ____/_____/_____

Signature of Patient or Patient's Authorized Representative **Date**

Representative's Name and Authority: _____