HIPAA Notice of Privacy Practices

Affiliated Retina Consultants
8 Arley Way • Suite 100
Bluffton, SC 29910
(843) 815-5436

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to retest to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Affiliated Retina Consultants, P.A.

PATIENT REGISTRATION & HISTORY

Date: _____ Referred By:_____

Name: Mr. Mrs. Ms._____
Last Name First Name Initial

Soc. Sec#_____ Home Telephone_____

Address_____

City _____ State _____ Zip Code_____

Sex: M F Date of Birth: _____Marital Status: Single Married Divorced Widowed

Occupation:_____

Patient Employed By: _____ Work Phone:_____

Patient Spouse Or Guardian:_____ Employer:_____

Nearest Relative Not Living With You:_____ Phone:_____

We will make photocopies of your insurance cards and any applicable information.

INSURANCE AUTHORIZATION

I, the undersigned have insurance coverage with _____
Name of Insurance Company

I assign directly to Dr. Scott Anfinson all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian:_____Date:_____

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Scott Anfinson for any services furnished me by or in Dr. Anfinson's office including physician services. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or any of its agents any information needed to determine these benefits or benefits for related services. I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Beneficiary Signature: _____Date:_____

(Please turn over to Pages 2 & 3)

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Email: _____

Primary Care Physician: _____

Referring Dr.: _____

Pharmacy: _____ Location: _____

How did you hear about our office? _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic Retired: ☐ Yes ☐ No

Occupation (if retired, past occupation) _____

Allergies: Reaction Severity

_____ _____

mild / moderate / severe

_____ _____

mild / moderate / severe

_____ _____

mild / moderate / severe

Past Ocular History: (Please mark all that apply)

☐ Overall Healthy ☐ Cataracts ☐ Hyperopia (Far sighted)

☐ Myopia (Near sighted) ☐ Amblyopia (Lazy eye) ☐ Diabetic Retinopathy

☐ Iritis ☐ Optic Neuritis ☐ Aphakia

☐ Dry Eyes ☐ Keratoconus ☐ Retinal Detachment

☐ Astigmatism ☐ Glaucoma ☐ Macular Degeneration

Other _____

Ocular Surgeries: (Please mark all that apply)

☐ No prior ocular surgery ☐ Foreign Body Removal ☐ Punctal Plugs

☐ Trabeculectomy ☐ Blepharoplasty ☐ Retinal Laser Surgery

☐ RK (Glaucoma surgery) ☐ Cataract Surgery ☐ LASIK

☐ Strabismus Surgery ☐ Vitrectomy ☐ Corneal Transplant

☐ PRK (eye muscle surgery)

Other _____

Ocular Significant Illnesses: (Please mark all that apply)

- ☐ Overall Healthy
- ☐ AIDS
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Herpes
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Rheumatoid Arthritis
- ☐ Hypothyroidism
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Sjogrens
- ☐ Graves Disease

Other _____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses:

- ☐ No history of illnesses
- ☐ Lung Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Polymyalgia
- ☐ Hearing Loss
- ☐ Psychiatric Disorder
- ☐ Kidney Stones
- ☐ Congestive Heart Failure
- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Liver Disease
- ☐ Bleeding Disorder
- ☐ Skin Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Headache
- ☐ Cancer

Other _____

General Surgeries / Operations: (Please list)

_____

_____

_____

Please continue on the back side of this page →

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

- ☐ Overall Healthy
- ☐ Syphilis
- ☐ Meningitis
- ☐ Histoplasmosis
- ☐ Herpes Simplex
- ☐ Chicken Pox
- ☐ Toxoplasmosis
- ☐ MRSA
- ☐ HIV /AIDS
- ☐ Herpes Zoster / Shingles
- ☐ Hepatitis A / B / C
- ☐ Wound Infection

Family History:

- ☐ Arthritis
- ☐ Stroke
- ☐ Lazy Eye
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Blindness
- ☐ TB
- ☐ Macular Degeneration
- ☐ Kidney Disease
- ☐ Glaucoma
- ☐ Cancer
- ☐ Cataracts
- ☐ Retinal Disease

Other_____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker

☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often? _____

Drug Use: ☐ Yes ☐ No If yes how much and how often? _____

Review of Systems: (Please mark all that apply)

Eyes

- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Pain
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose, and Throat

- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Cardiovascular

- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath

Respiratory

- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal

- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitus

Genito-Urinary

- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's

Psychiatric

- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Blood / Lymphnodes

- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

Musculoskeletal

- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin

- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological

- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

FINANCIAL POLICY

OFFICE VISITS AND SERVICES

Our office policy is to request payments at the time service is rendered. For your convenience, we accept cash or personal check. We will file your insurance claims for you if applicable. However, you remain responsible for any co-payment amount, deductible, co-insurance, and any other amount deemed to be your responsibility by your insurance carrier. Please notify our office if you will be unable to render payment; we are willing to make acceptable arrangements for any balance.

IMPORTANT INSURANCE INFORMATION

- ◊ We participate with a large number of health insurance plans. We will bill your insurance directly for your services. It is **crucial** that you provide our office with your most recent and updated copies of any insurance cards.
- ◊ If you are covered by more than one policy, please let us know which is your primary insurer.
- ◊ **Co-payments are due at the time of service.** This is a requirement set forth by your contract with your insurance carrier. The amount of the co-payment is usually listed on the insurance identification card.
- ◊ Some insurance plans require that members obtain referral authorization from their insurance plan or primary care physician. If you are in a plan, please remember **it is the patient's responsibility to obtain authorization prior to a visit even if the problem is urgent.** Failure to comply with this requirement may result in reduced payment from your insurance carrier which in turn may result in an increase in your financial responsibility.
- ◊ We will obtain necessary pre-certification and/or authorization related to office procedures, testing, or hospital-based surgeries.
- ◊ Occasionally, insurance companies require patients to complete questionnaires to determine if the patient has other health insurance. If your carrier sends you a notice to this effect, please complete quickly. The carrier **will not** provide reimbursement until any necessary forms are filled out and returned.
- ◊ Remember, your health insurance policy is a contract between you and your insurance company. You pay the premiums to the company in return for medical coverage. Our office has no relationship in determining the level of benefits available to you by the carrier, nor are we able to negotiate settlement of disputed claims.

SELF-PAYING PATIENTS

If you do not have health insurance coverage, but need our services, please let us know. We will be glad to assist you with a reasonable payment schedule. Please notify us prior to service so that we my help you with arrangements.

WORKMAN'S COMPENSATION

We will file your Workman's Compensation claims. **You must provide us with the claim number, contact person, and any applicable telephone numbers for us to file the claim.** Your employer is responsible for completion of all documents, forms, etc. required by the Workman's Compensation carrier to document your injury, and submit the claims.

ACCOUNT BALANCES

Our office processes statements of accounts every 30 days. Patient balances will be outlined as well as insurance due if applicable. **However, accounts must be paid in full within 90 days of services rendered unless prior arrangements have been made.**

You are responsible for payment of your medical care within a reasonable time frame regardless of insurance claim status. If prior arrangements have not been made, and full payment is not made within 90 days, collection action will be taken.

We understand that medical expenses are usually unexpected, and can create financial hardships. We encourage open communication regarding your ability to pay your bill. Insurance often does not pay the full cost of medical bills, nor do they always pay in a timely manner. We are willing to work with you if you work with us.

WE ARE HERE TO ASSIST YOU.
Please feel free to call us with any questions regarding our services.

Patient's Signature_____
Date_____