VISION PLUS

PATIENT REGISTRATION INFORMATION

Patient Name (Last, First, MI) _____ **Date** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth _____ **Social Security Number** _____-_____-_____ **Sex** □ Male □ Female

Guarantor □ Self □ Other _____ **Relation to Patient** _____ **Phone #** _____

Preferred Language □ English □ Spanish □ Other _____

Race/Ethnicity □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander □ White □ Other_____

Preferred Phone # _____ □ Home □ Work □ Cell **Email** _____

*****Consent for Contact is implied for all methods provided unless otherwise specified*****

Employment Status □ Full Time □ Part Time □ Not Employed □ Retired □ Active Military □ Student

Employer_____ **Position** _____

Emergency Contact _____ **Relation to Patient** _____ **Phone #** _____

Family members to link accounts _____

Do you have Diabetes? □ No □ Yes, **Type** _____ **Last A1c (if known)** _____ **Date tested** _____ **Age at Onset**_____

Are you presently taking any medications? □ No □ Yes If yes, please list _____

Are you allergic to any medications? □ No □ Yes If yes, please list (with reaction)_____

List any current medical conditions: _____

Explanation of health history: _____

Have you ever had any eye disease, eye injury or eye surgery? □ No □ Yes If yes, explain _____

When was your last eye examination? _____ **When was your last medical examination?** _____

Primary Care Physician Name _____ **Phone** _____

Vision Plus is a Medical Optometry Practice. Based on the Doctor's findings during your visit, we may be required to utilize one or both of your Vision and/or Medical Insurance Plans. Please provide as much information as possible for each to allow for proper verification.

Vision _____ **Member ID** _____ **Group Number** _____

Primary Insured □ Self □ Other Name _____ Relation to Patient _____

Date of Birth _____ Social Security Number _____-_____-_____ Sex □ Male □ Female

Medical _____ **Member ID** _____ **Group Number** _____

Primary Insured □ Self □ Other Name _____ Relation to Patient _____

Date of Birth _____ Social Security Number _____-_____-_____ Sex □ Male □ Female

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I hereby authorize treatment by this office. If insurance coverage is indicated, I further authorize the release of any medical or other information necessary to process this claim with my Insurance Plan(s). I agree to pay any co-payment due at the time of service. In the event that my Insurance Plan determines that I am not eligible at the time of service or that I am eligible for a reduced level of coverage due to not met deductibles or any other reason, I agree to pay any and all charges incurred by me and not paid by the Plan.

Signature of Patient (or Guarantor) _____ **Date** _____

VISION PLUS
RETINAL EXAM ADDENDUM

A retinal exam is an important part of a comprehensive eye health evaluation. The retina is a thin layer of tissue at the back of your eye that transforms light and images into nerve signals sent to your brain. It is a vital part of your vision and overall eye health. However, the retina can be affected by various diseases and conditions such as diabetes, glaucoma, macular degeneration, cataracts, and high blood pressure. The retina can also tear or detach due to factors such as injury, aging, or family history. Regular retinal exams can help detect and treat these problems before any symptoms or vision loss occur and before they become irreversible.

Vision Plus offers two types of retinal exams:

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes. This allows your doctor to obtain the most optimal view of the retina. The effects of dilation will last for 2-3 hours and you may experience sensitivity to light and blurred vision while reading. Most people **will** be able to drive while their eyes are dilated. However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver. Please note that there is no additional charge for the dilation, as it is included as a part of the comprehensive eye exam.

The optomap® **(digital image of the retina)** is fast, safe, and effective and allows for easy imaging of both adults and children. To have the exam, a patient simply looks into the device one eye at a time (like looking through a keyhole), and a quick flash of light confirms the ultra-widefield retinal image has been captured and transferred to a special computer program for the doctor to review with you. This advanced screening technology is not yet covered by most insurance plans but may be added as an enhancement to your annual eye exam for **only $25.** *(Patients with Diabetes or other issues may still need to be dilated.)*

Please choose one:

☐ I prefer to have my eyes dilated for a retinal exam during today's visit. I understand the after-effects of dilation as stated above.

☐ I prefer to have the **opto**map® retinal screening added to today's visit. I understand that I may be charged $25.00 in addition to any applicable exam co-pays.

☐ I decline to have either type of retinal exam offered during today's visit. I understand the risks associated with not receiving regular retinal exams.

_____

Signature of Patient/Guardian Date

VISION PLUS

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ [please print full legal name here] (the "Patient" or "Patient's Legal Representative"), have been presented with the Notice of Privacy Practices Policy (the "Policy") of **Vision Plus LLC/Thomas J. Goldstein, O.D./any associated provider** (the "Provider"), and have been offered a copy of such policy to keep for my records.

[Please initial only one of the below options]

_____ I hereby acknowledge that I have been provided with a copy of the Policy.

_____ I hereby refuse to acknowledge receipt of the Policy. I understand that, even though I may refuse to sign this acknowledgment, the Provider may still provide treatment to me.

I consent to allow the Provider to share my records/personal information with the following individual(s):

_____

Signature of Patient or Legal Representative _____ Date _____

FOR OFFICE USE ONLY

I, _____ [please print full legal name here], acting as _____ [please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgement of receipt of the Policy of the Provider on _____ [please insert date attempt was made], but acknowledgment could not be obtained because:

[Please initial only one of the below options]

_____ Patient or Patient's Legal Representative refused to sign.

_____ Patient or Patient's Legal Representative could not be communicated with sufficient to obtain acknowledgment.

_____ Emergency circumstances prevented securing acknowledgment.

_____ Other (please specify) _____

_____

Signature of Provider Representative _____ Date _____

VISION PLUS
NOTICE OF PRIVACY PRACTICES

3331 WURZBACH ROAD, SUITE B, SAN ANTONIO, TEXAS 78238
(210) 520-6353
JENNIFER GOLDSTEIN, PRIVACY OFFICIAL

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails, texts, or emails; calling your name out in a reception room environment; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails, texts, or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails, texts, or emails reminding you it is time for continued care; at your request, we can provide you with a copy of your medical records via email transmission or through our secure patient portal.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; sending notices of payment due on your account to the person designated as responsible party or head of household on your account with fee explanations that could include procedures performed and for what diagnosis: collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office. At the patient's request, we may not disclose health care information for services you paid for out of pocket. This only applies to those encounters related to the care you want restricted.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits; providing information regarding your vision status to the Department of Public Safety, a school nurse, or agency qualifying for disability status.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDING PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures
- Disclosure of information needed in completing form from a school related vision screening, information to the Department of Public Safety, information related to certification for occupational or recreational licenses such as pilots license.
- Disclosures to business associates who perform health care operations for Vision Plus and who commit to respect the privacy of your information. We also require a business associate to require any sub-contractor to comply with our privacy policies.
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Vision Plus for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Vision Plus staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Vision Plus staff and doctors will also infer that if you allow another person in an examination room, treatment room, dispensary, or any business area within the office with you while testing is performed or discussions held about your vision or health care or your account that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Vision Plus or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We may accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

Health care information you request copies of may be delivered to you in electronic format. The e-formats Vision Plus has approved as secure and protects the integrity of your health care information include secure email, an authorized Electronic Health Information system and media supplied by Vision Plus or you.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Vision Plus. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $25.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office.

BREACH NOTIFICATION POLICY

In the event of a reportable breach of patient information, Vision Plus agrees to abide by the breach notification requirements as established by the HIPAA Breach Notification Rule. If a breach occurs, Vision Plus will consult with a HIPAA attorney and take all necessary steps to remain in compliance with this rule including notification of individuals, Business Associates, the Secretary of Health and Human Services and prominent media outlets.

WHISTLEBLOWER PROTECTION RULE

Vision Plus will take no action against any individual who provides information to the Office of Civil Rights, Office of the Inspector General or individual state Attorney General's Office regarding concerns related to the privacy and security procedures or actions at Vision Plus.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to substantially change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office.

COMPLAINTS

If you think that anyone at Vision Plus has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights or the Texas Attorney General's Office. We will not retaliate against you if you make such a complaint.