



NORTH BAY EYE ASSOCIATES

Welcome to North Bay Eye Associates!

We are looking forward to meeting you at your scheduled appointment on _____, at our office. At the time of your appointment please bring the following information with you:

- Completed forms
- Current medical and vision insurance cards
- Referral form (if required by your health plan)
- Current glasses (even if broken)
- Current contact lens information and packaging if available
- List of all oral medications and bring any eye drop bottles that you are currently using
- Minors must be accompanied by parent or legal guardian

We request that you kindly give us 24 hours notice if you are unable to keep your appointment. Should you arrive more than 15 minutes late of your scheduled appointment, you may be delayed or asked to reschedule depending on other patients waiting for our services.

Our entire office staff would like to welcome you to our office as well as thank you for selecting us to serve your vision care needs. We look forward to providing you with the personal and professional vision care you deserve.

Please feel free to call us with any questions you may have concerning your vision care.

Sincerely,

North Bay Eye Associates, Inc.

Office Procedures

If this is your first visit to our office or you are scheduled for a dilated eye exam, please plan to be in our office for at least 1 ½ hours. The dilation process in children often takes up to 45 minutes. Therefore, please plan 2 hours for children's eye exams. Due to the fact that your eyes will remain dilated after your visit, please be sure to bring sunglasses with you.

After your initial visit, an appointment card will be provided to you. We make every effort to see you at the time of your appointment. Please remember, however, that sometimes situations beyond our control will arise causing us to be delayed. If, for any reason, we are running behind, we will do our best to keep you informed. If this occurs and you are unable to wait, please inform our receptionist and we will reschedule at the earliest appointment time that we have available to accommodate you.

PAYMENT IS DUE AND PAYABLE AT THE TIME THAT THE SERVICES ARE PROVIDED, UNLESS YOU ARE A MEMBER OF A HEALTH PLAN OR PREFERRED PROVIDER ORGANIZATION TO WHICH WE BELONG. If you are a member of such an organization, payment of your co-pay, deductible and/or co-insurance is due at the time of service. *Failure to pay your copayment at the time of service will result in a \$15 service charge being added to your account.* For non-fixed co-payment plans, a minimum of 20% of the total visit fee is due at the time of service. Unaccompanied minors should be provided with the appropriate payment or co-payment. Payment may be made by cash, check or accepted credit cards.

All returned checks are subject to a \$25.00 processing fee.

Past Due Accounts

We will make every effort to work with you in payment of past due balances. However, past due accounts for which no mutually agreed payment arrangements have been made for payment will be turned over to a collection agency.

Contact Lens patients

On your initial visit, the doctor will perform a complete, comprehensive eye examination to determine the health of your eyes. If you wear contacts, there are additional information that needs to be checked for the safety of our patients. There will be a \$25.00 assessment fee which will not be paid by insurance. If the doctor determines you to be a candidate for contact lenses, a SEPARATE fitting appointment will be scheduled at an additional charge. If you are an existing contact lens wearer who has purchased your lenses elsewhere or wishes to change the type of lens you are wearing, a SEPARATE appointment will be scheduled to evaluate and refit your lenses at an additional charge.

Missed Appointments

Patients who fail to keep appointments or who do not give us 24 hours notice to reschedule the appointment are subject to pay a fee. After consecutive missed appointments, we will ask you to seek medical care elsewhere. Patients who arrive 15 minutes or more after their scheduled appointment time may be asked to reschedule.

Telephone Calls

Please call the office if you have any questions regarding your treatment or medication. Our office personnel can often assist in arranging for prescription refills as well as help answer any questions that you may have. If no one is available when you call, we will do our best to return your call in a timely fashion. Please allow 24 hours for prescription refills. Thank you.

PATIENT INFORMATION

04/15/11

Name:		Gender:	
Date of Birth:	Age: Single / Married / Widowed / Separated / Divorced		
Billing Address:	City:	State:	Zip Code:
Street Address:	City:	State:	Zip Code:
Daytime Phone:	Alternate Phone: ext.		
Social Security #:	Primary Language:	State:	

If the patient is a minor, the following must be completed:

Responsible Party:	Relationship to Patient:	Social Security #:
Address (if different from patient's)		

All patients and / or responsible parties please complete the following:

Employer:	Occupation:	Business Phone:
Business Address:		
Driver's License #:	Would you prefer to be contacted by: Phone Regular Mail	
Name of Insurance Plan:	Family Physician:	
Insurance Subscriber's Name:	DOB:	Social Security #:
Subscriber's ID	Employer:	
In case of emergency, who should be notified?		Phone #:
Allergic to following medications:		Pregnant/Nursing?

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to North Bay Eye Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that since the services were provided to me, I am ultimately financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured / Guardian: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to North Bay Eye Associates for any services furnished to me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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 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. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurances and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured / Guardian: _____

PLEASE COMPLETE IF PATIENT IS UNDER 18

In case of my absence, I hereby give permission to North Bay Eye Associates for treatment as they deem necessary to my child.

Signature of Responsible Party: _____

NORTH BAY EYE ASSOCIATES, INC. NOTICE OF PRIVACY PRACTICES

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

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to: (1) Maintain the privacy of medical information provided to us; (2) Provide notice of our legal duties and privacy practices; and (3) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the practices of all North Bay Eye Associates, Inc. employees and staff and Archambeau Surgery Center employees and staff. This notice applies to each of these individuals, entities, sites and locations.

INFORMATION COLLECTED ABOUT YOU:

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and telephone number
- Information relating to your medical history
- Your insurance information and coverage
- Information concerning your doctor, nurse or other medical providers

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" such as the referring physician, your other doctors, your health plan, and family members or close friends.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU:

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

- **Required Disclosure:** We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.
- **For Treatment:** We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.
- **For Payment:** We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give the payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.
- **For Health Care Operations:** We may use and disclose information about you for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.
- **Public Policy Uses and Disclosures:** There are a number of public policy reasons why we may disclose information about you. We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive protected health information for the purpose of preventing or controlling disease or disability, at the direction of a public health authority, or to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally, we may disclose protected health information to a person subject to the Food and Drug

Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to a medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorized the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies that are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is necessary for determining compliance with program standards, or 3) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposed also permit use to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information; 1) to a coroner or medical examiner to identify a deceased person or determine the cause of death, 2) to funeral directors, or 3) to organ procurement organizations, transplant centers, and eye or tissue bank if you are an organ donor.

We may release your health information to worker's compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault.

Health information about you may also be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or similar body referred to as a Privacy Board determines that your privacy interest will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We may also release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign Heads of State.

- **Our Business Associates:** We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.
- **Disclosures to Persons Assisting in Your Care or Payment for Your Care:** We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. **However, under circumstances such as in an emergency situation, we may make these uses and disclosures without your agreement.**
- **Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.
- **Treatment Alternatives:** We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other use or disclosure of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent of the information already released pursuant to your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use or disclose your health information for treatment, payment and health care operating purposes. You may also request that we limit our disclosures to persons assisting in your care or payment for your care. We will consider your request, but reserve the right to deny any such request.

You have the right to request that you receive communications containing your protected health information from us by alternative means or alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate or complete.

You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses and disclosures before April 14, 2003, among others. You may be charged a fee if you request this information from us more than once every twelve months.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.

To exercise any of your rights, please contact us in writing at **North Bay Eye Associates, Inc., Attn: Administration Office, 50 Professional Drive, Suite 210, Rohnert Park, CA 94928**. When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practice, you may contact the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington DC 20201. (E-mail: ocrmail@hhs.gov) You may also contact us at North Bay Eye Associates, Inc., Attn: Administration Office, 50 Professional Drive, Suite 210, Rohnert Park, CA 94928 (707)588-7942.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.