

## EyeQ Eyecare and Eyewear PLLC

### Insurance Policies and Billing Procedures and Privacy Practices Acknowledgement

I authorize EyeQ Eyecare and Eyewear LLC to use this authorization in place of my physical signature on submissions to my insurance carrier and/or vision supplement.

I authorize assignment of payments directly to EyeQ Eyecare and Eyewear LLC when applicable.

I understand that it is my responsibility to know the details of my individual insurance plan deductibles and co-pay/co-insurance amounts. I also understand that it is my responsibility to present all insurance on or before day of service.

I understand that although a procedure may be covered by my insurance, I may have amounts out-of-pocket for co-pays, co-insurance, and deductible that will be payable to EyeQ Eyecare and Eyewear.

I understand I am ultimately responsible for my/my dependents charges if unpaid or denied by insurance, as my insurance is a contract between myself and my insurance company and payment for materials and services rendered is due regardless of insurance determination of coverage.

In the event that an outstanding balance is transferred to collections, after 120 days past due, a collections fee equal to 25% of unpaid balance will be added to amount due.

I understand that the billing of insurance is determined by the reason for my visit as well as ultimate diagnosis. I understand that vision insurance (ie. Eyemed, VSP, Avesis, etc.) covers only routine/preventative eye examinations for purposes of vision correction and/or eye health screening.

I understand that examinations for concerns such as diabetes, cataracts, glaucoma, eye pain, redness, "spots in vision", dry eye, blurry vision not due to the need for glasses/contacts, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider.

I understand that, outside of urgent eye issues or issues affecting vision and determination of your glasses or contact lens prescription, I can request that my vision plan be used if eligible and may then return at a later date and time to address specific medical eye concerns.

I have been given or offered a copy of this practice's notices of HIPAA privacy practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

#### **Deceased Persons**

We may disclose your health information to coroners or medical examiners.

#### **Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

#### **Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

#### **Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

#### **Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### **Change of Ownership**

In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

#### **3<sup>rd</sup> parties with whom we have a HIPAA compliant BAA and/or are required for the completion of business related tasks.**

These include our phone company for reminder texts/calls/emails, our electronic records vendor, frame, contact lens, optical lens vendors, credit card processor, etc- we will only disclose as much identifiable information as necessary to complete business interactions and nothing more.

#### **Your Health Information Rights:**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.

- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

#### **Changes to this Notice of Privacy Practices**

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: us by calling this office. If the Doctor is not available, you may make an appointment for a personal conference in person, or by telephone within two working days.

#### **Complaints**

Complaints about your Privacy rights or how this practice has handled your health information should be directed to the doctor, by calling this office. If the doctor is not available, you may make an appointment for a personal conference in person, or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

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