1604 Sulphur Springs Road,
Waynesville, NC 28786,
United States

Phone: (828) 456-8361
Fax: (828) 452-4527
Email: office@haywoodfamilyeye.com
Website: www.haywoodfamilyeye.com

This document contains all agreements, disclosures, and notices pertaining to your care and your rights with Haywood Family Eye Care. Please review each section carefully.

SECTION 1: FINANCIAL ASSIGNMENT AND AGREEMENT

I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductibles, copays, or other charges not paid by my insurance company. I authorize Haywood Family Eye Care to bill my insurance company for services provided to me and authorize insurance benefits to be paid directly to the provider.

Payment Policy:

- Payment for all services is due at the time they are rendered unless prior arrangements have been made.
- Full payment for any products, including but not limited to eyeglasses, contact lenses, vitamins, supplements, and other optical or healthcare-related products, is required before the order is placed or the products are dispensed.
- If insurance benefits are used, any amount not covered by the insurance, including copays, deductibles, and any non-covered services or materials, will be the patient's responsibility and must be paid at the time of service.

SECTION 2: DILATION

You may have dilation drops instilled in your eyes as part of your eye examination. The drops may cause light sensitivity and blurred vision. The drops allow the doctor to get a comprehensive view of your eye health.

SECTION 3: ABOUT YOUR INSURANCE

There are two types of insurance that will help pay for your eye care services and/or optical products. You may have both types, and Haywood Family Eye Care accepts most insurance plans in both categories:

1) Vision Plans (such as VSP, EyeMed, Spectera, and others)
2) Medical Insurance (such as Blue Cross/Blue Shield, Medicare, and others)

Vision plans only contribute towards routine vision wellness exams, along with eyeglasses or contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems).

Medical insurance must be used for medical eye care.

If you have both types of insurance plans, it may be necessary for us to bill some services to your vision plan and some services to your medical plan. We will follow a procedure called Coordination of Benefits to do this properly and to minimize your out-of-pocket expenses.

SECTION 4: NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices ('Notice') describes how we may use or disclose your health information and how you can get access to such information. Please read it carefully.

Your 'health information,' for purposes of this Notice, is generally any information that identifies you and is created, received, maintained, or transmitted by us in the course of providing health care items or services to you (referred to as 'health information' in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ('HIPAA') and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment, or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us.

Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). 'Health care operations' mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health-related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- 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 or disclosures;
- Disclosures to 'business associates' and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- Any other uses and disclosures affected by state law.

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

CONSENT TO OBTAIN MEDICATION HISTORY

As part of your health care team, we use our electronic medical record system to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors or providers have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. As such, we have your consent to collect your medication history, and you also give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your verbal or written authorization.
- You have the right to authorize us, verbally or in writing, to disclose your health information to individuals who are directly involved in your care. With your consent, we will add these individuals to your account, allowing them to receive relevant health information necessary to assist in your care.
- We will obtain your verbal or written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment, and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information, we may charge you a fee for the cost of copying, mailing, or other supplies. In certain circumstances, we may deny your request to inspect or copy your health information, subject to applicable law.
- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not

in writing or does not provide a reason to support your request. We may also deny your request if the health information:
    - Was not created by us, unless the person that created the information is no longer available to make the amendment,
    - Is not part of the health information kept by or for us,
    - Is not part of the information you would be permitted to inspect or copy, or
    - Is accurate and complete.
- To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- To designate another party to receive your health information. If your request for access to your health information directs us to transmit a copy of the health information directly to another person, the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.
- To request an electronic copy of your health information. You may request that we provide an electronic copy of your health records in a format of your choice, if it is readily producible in that format.
- To be notified of a breach. If a breach of your unsecured health information occurs, we will notify you without unreasonable delay and in no case later than 60 days following the discovery of the breach. The notification will include a description of the breach, the types of information involved, the steps you should take to protect yourself, what we are doing to investigate the breach and mitigate the harm, and contact information for further inquiries.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be available on our website at HaywoodFamilyEye.com. Copies of this Notice are also available upon request at our reception area.

CONTACT PERSON:

Please direct all questions, requests, or further information related to the privacy of your health information to our Office Manager at office@haywoodfamilyeye.com.

COMPLAINTS:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or email shown above. If you prefer, you can discuss your complaint in person or by phone.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. For more information, visit the OCR website at www.hhs.gov/ocr/privacy/hipaa/complaints/ or call 1-800-368-1019.

NOTICE REVISED AND EFFECTIVE: August 30th, 2024

SECTION 5: AGREEMENT FOR DIGITAL DELIVERY OF PRESCRIPTIONS

By signing this agreement, you consent to receive both your eyeglass and contact lens prescriptions electronically via the Haywood Family Eye Care online patient portal. You acknowledge and agree that:

1. **Digital Delivery Consent:** Your eyeglass and contact lens prescriptions will be made available to you electronically through our secure online patient portal immediately after they are finalized. By agreeing to this method, you accept digital delivery as sufficient in lieu of receiving a paper copy, unless specifically requested otherwise.
2. **Combined Consent for Eyeglass and Contact Lens Prescriptions:** This agreement covers digital delivery for both your eyeglass and contact lens prescriptions. By consenting, you acknowledge that both prescriptions will be provided electronically unless you request a paper copy.
3. **Special Circumstances:** In situations where a prescription is not standard or 'Rx-able' (e.g., due to certain medical conditions or specific treatments), you understand that you will be informed, and a notation will be made in your medical record to document why a prescription was not provided.
4. **Right to a Paper Copy:** You understand that you have the right to request a paper copy of your eyeglass and/or contact lens prescription at any time, at no additional cost. If you prefer to receive your prescriptions on paper, please inform us during your visit or at any time thereafter.
5. **Exceptions and Adjustments:** If there are exceptions, such as a prescription that requires adjustment after dilation or further examination, you will be notified accordingly. The prescription will be made available to you digitally once it is finalized.
6. **Consent Withdrawal:** You may withdraw your consent for digital delivery at any time by notifying us in writing or via the patient portal. Once consent is withdrawn, all future prescriptions will be provided to you in paper form unless you request otherwise.
7. **Data Privacy:** Your prescription information will be securely stored and accessible only to you through your patient portal account. We are committed to protecting your personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
8. **Record Keeping:** We will maintain a record of your consent for a minimum of three years, as required by law.

FINAL AGREEMENT AND SIGNATURE

By signing below, you acknowledge that you have read, understand, and agree to all the terms and conditions contained in this document, including all sections related to financial responsibility, privacy practices, digital delivery of prescriptions, and your rights under the Health Insurance Portability and Accountability Act (HIPAA).

Signature	Printed Name	Date