

Checklist for Your Eye Doctor Appointment at Lifetime Eyecare Associates

Have you ever left the doctor's office and thought of a dozen questions you meant to ask? We all do that!

We hope this checklist will help make visit to the eye doctor your best ever.

When you call to make an appointment:

- Describe any vision problems you are having.
- Ask if you will be able to drive yourself home and if the eye examination will temporarily affect your vision?
- Ask how much the exam will cost and if your insurance is accepted.

Before you go for your examination

Make a list of the following:

- Signs or symptoms of eye problems you have noticed (flashes of light, difficulty seeing at night, temporary double vision, loss of vision, etc.)
- Eye injuries or eye surgery you have had (approximate dates, hospitals where treated, etc.)
- Prescription and over-the-counter drugs you are taking.
- Questions you have about your vision.
- Your general health condition (allergies, chronic health problems, operations, etc.)
- Family history of eye problems (glaucoma, cataracts, etc.)

Take along the following:

- Your glasses, prescription sunglasses and/or contact lenses.
- A list of prescription(s) and over-the-counter drugs you are currently taking.
- Vision insurance information
- Medical or health insurance card(s) or your membership certificate.

During the examination

- Ask questions about anything that seems unclear to you, such as the names and purposes of tests you may undergo.
- Ask if there are any changes since your last exam.

Find out when you should return for your next exam.

INTERIM MEDICAL HISTORY

Name _____ SS # _____ Date _____

Mailing Address _____

Phone (____)_____-____ Daytime Phone (____)_____-____ Cell Phone (____)_____-____

Email Address: _____

What medications (Rx & OTC) do you **currently** take? _____

Have you had any surgeries since your last visit? _____

Have you had any major illnesses or injuries since your last visit? _____

Have you had any changes in any of the following areas? If yes, please explain:

Yes	No	Area	Explanation of Problem
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	_____
<input type="checkbox"/>	<input type="checkbox"/>	General Health	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Throat	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	_____
<input type="checkbox"/>	<input type="checkbox"/>	Genital, Kidney, Bladder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscles, Bones, Joints	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergic, Immunologic	_____

Lifestyle Questions.....

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you participate in a Flexible Spending Plan through your insurance company? |
| <input type="checkbox"/> | <input type="checkbox"/> | Work at a computer? |
| <input type="checkbox"/> | <input type="checkbox"/> | Think you might benefit from thinner, lighter lenses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have an interest in a "test drive" of the latest contact lens designs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Spend times outdoors? _____ Hrs per week |
| <input type="checkbox"/> | <input type="checkbox"/> | Have prescription sunglasses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Prefer not to wear your glasses at times? |
| <input type="checkbox"/> | <input type="checkbox"/> | Want information Laser Vision Correction Surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have more than one current pair of prescription glasses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Enjoy outdoor recreation such as golf, tennis, or fishing? |

HIPAA PRIVACY ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print full legal name of patient or patient's legal representative), have been presented with the Notice of Privacy Practice of Lifetime Eyecare Associates, and have been offered a copy of such policy to keep for my records.

- I hereby acknowledge that I have been provided with a copy of the policy
- I hereby decline a copy of the Policy. I understand that although I have not received a copy of the policy, an optometrist of *Lifetime Eyecare Associates* may still provide treatment for me.

Signature of patient or legal representative

Date

PATIENT FINANCIAL RESPONSIBILITY

Patient Name _____

Insurance _____

Insurance plans vary greatly in their coverage, even within the same insurance company. Your insurance plan may not pay for all your vision care costs. It will only pay for a percentage of covered items and services when all the rules are met. We make every attempt to find out what your insurance will cover before services are provided; however, only after the claim has been processed can we be sure of the actual coverage provided.

Payments for services not covered by insurance are due at the time of service. Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not *Lifetime Eyecare Associates*.

You are responsible to pay for:

- All co-pays
- All deductible amounts
- Your percentage of covered items and services
- Any items and services which your insurance company identifies as "non-covered"

We will, in most cases, file your insurance claim as a service to you. However, if your insurance company has not paid within 60 days, you will be responsible for the charges in full. Should your account become delinquent and need to be turned over to collections, there will be a 15% fee added to the outstanding balance.

I understand and agree to the conditions outlined above.

Signature of patient or legal representative

Date

Please provide the following information for insurance purposes:

Primary Insured's *(not insurance company name)*

Name _____

SSN _____ / _____ / _____ DOB _____ / _____ / _____

Address _____

Secondary Insurance Member *(not insurance company name)*

Name _____

SSN _____ / _____ / _____ DOB _____ / _____ / _____

Address _____

Lifetime Eyecare Associates
NOTICE OF PRIVACY PRACTICES

Jeremy R Burns, O.D.
2428 Reidville Road
Spartanburg, SC 29301

Office 864.576.7225

Fax 864.576.7226

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you 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 reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose 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 have to do 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. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information.

You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.