NAME _____ DATE OF BIRTH _____

SS# OF CONTRACT HOLDER HOME PHONE ( ) _____

ADDRESS CELL PHONE ( ) _____

CITY/ZIP ____WORK # OF PARENT OF PATIENT IS MINOR ( ) _____

MEDICAL DOCTOR DOCTOR'S PHONE # ( ) _____

CHART # TODAY'S DATE LAST EYE EXAM REFERED BY _____

HISTORY: FLASHES FLOATERS DIPLOPIA HDCH
MEDS:

ALLERGY: CC:

GLAUCOMA:

PGH:

OLD RX

OD

OS

ADD:

AIDED
VA 20/

UNAIDED
VA 20/

KERATOMETRY

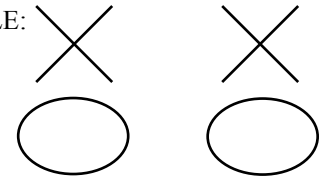
OD:

OS:

OCULAR HEALTH:
VERSIONS:
PUPILS:
CT:
CFVF:
TAP:
NCT:

DFE:
1% 90D
2 1/2 % P 20D
1 % C 78D

SLE:



BVA

OD:

OS:

ADD:

FINAL RX

OD:

OS:

ADD:

SPECIAL TEST OR COMMENTS

A1. P1.

CONTACT: SPHERE EQU.

OD:

OS:

FINAL FITTING

OD:

OS:

VDT / SAFTEY

Morris Avenue Eyecare

Icare Eyecare, Inc.

Dr. Valencia Wells, O.D.

Notice of Information Practices and Privacy Statement

2229 Morris Avenue, Birmingham, AL 35203

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

Our Legal Duty

We are required by law to maintain the privacy of our health information, to provide you with this notice of its legal duties and privacy practices with respect to your health information, and to follow the terms of this Notice. We will not use or disclose medical information about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and the terms of this Notice at any time, provided that the changes are permitted by law. Changes to our privacy practice or terms of this Notice effect all medical information we keep, including previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

This section describes how your medical information may be disclosed. This section is representative, but not all inclusive.

- Treatment, Payment, and Health Care Operations – We may use medical information obtained from you in your treatment or services, to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you.
- As and When Required by Law - We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc), Court Orders and Judicial and Administrative, Deceased Person Information. Worker Compensation programs, or for Specialized Government Functions (military personnel and veterans, national security, or correctional facilities).
- Disclose to Our Business Associates – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- Victims of Abuse, Neglect, or Domestic Violence – We may disclose your health information to a government authority, such as social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share you medical information if there is a serious threat to your health or safety or the health or safety of others.
- Appointment Reminders & Alternative and Additional Medical Services – We may contact you to provide appointment reminders, annual eye examination cards, and other information about treatment alternative or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for you care.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products to services relating your treatment, care, or alternative treatments, or providers without authorization.

When We May Not Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Morris Avenue Eyecare will not use or disclose your health information without your written authorization. If you do authorize Morris Avenue Eyecare to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

Your Individual Rights When Respect to Your Health Information

- You have the right to request additional restrictions on certain uses and disclosures of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency)
- You have the right to inspect any copy your health information as long as Morris Avenue Eyecare maintains the health information. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be changes for copying, mailing, or other supplies necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- You have the right to request that we amend your health information that is incorrect or incomplete. We may deny your request if we did not create the information you want changed or for certain other reasons. If denied we will provide you with a written explanation.
- You have the right to receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- You have the right to request that we communicate with you about your medical information by different means or to different locations. You request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.

If you would like to exercise one or more of these rights, contact the location that provided you services or submit a written request to Valencia R. Wells, O.D., HIPAA Coordinator, 2014 Morris Avenue Birmingham, AL 35203.

Questions and Complaints

If you have questions or about this notice please ask to speak with our Privacy Officer. If you believe your privacy rights have been violated, you may speak with our Privacy Officer and submit a written complaint. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint.

PATIENT INFORMATION

NAME_____ TODAY' DATE _____DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____AGE_____

HOME PHONE _____ WORK PHONE _____

SEX M ___ F ___ OCCUPATION _____ HOBBIES _____

MARITAL STATUS S ___ W ___ D ___ M ____ EMAIL _____

SPOUSE' NAME _____ SS # _____ DOB _____

REASON FOR TODAY'S VISIT (Check all that apply) EYE EXAM _____ CONTACT LENS EXAM _____

NEW GLASSES ____ OTHER (please explain) _____

CONTACT HOLDER INSURANCE INFORMATION

MEMBER'S NAME _____ EMPLOYER _____ INSURANCE GROUP _____

MEMBER'S SOCIAL SECURITY # _____ MEMBER'S DATE OF BIRTH _____

MEMBER'S HOME PHONE _____ MEMBER'S WORK PHONE _____

MEDICAL HISTORY

When was your last eye exam? _____ yrs. Contact fit? _____ yrs.

Are you taking any medication? Please list, including birth control pills _____

Please list known medical allergies:

_____

_____

Please check any of the following that apply to you (if pertains to a family member, use the appropriate initial: M=mother, F=father, B=brother, S=sister, GP=grandparent, C=children)

____ glaucoma	____ eye irritations	____ kidney disease	____ arthritis	____ cataracts
____ flashes of light	____ thyroid disease	____ cancer	____ eye injury	____ spots in vision
____ heart disease	____ color blindness	____ eye surgery	____ eye infection	____ high blood pressure
____ diabetes	____ sickle cell disease	____ headaches	____ sarcoid	____ lazy eye (amblyopia)

____ contact lens complications ____ other (explain) _____

I have received a copy of Morris Avenue Eyecare's privacy policy.

Date _____

Signature _____

Privacy Policy

In order to ensure compliance with the Health Care Information Portability and Accessibility Act of 1996 (HIPAA), this practice has established a privacy policy to provide for the security of your medical records. Following is a summary of the contents of the Privacy Policy of this practice:

All patient records shall be stored in a closed filing system with access restricted to qualified personnel.

NO patient information shall be shared with another health care provider without the patient's written, signed consent with the exception of a medical emergency where the patient's life may be compromised without said information.

NO patient information, including but not limited to medical information, demographic information, lifestyle information, and financial information shall be released for the purpose of marketing outside of this practice.

This practice may send appointment reminders to help the patient preserve both their ocular and general health. If you do not wish to receive these appointment reminders, please notify one of our staff members.

Any and all computer terminals containing patient information are secured by password protection with only qualified staff possessing a password to access the computer systems.

If you have any questions or concerns about your privacy and your medical records, please do not hesitate to ask the doctor. A complete copy of this office's Privacy Policy is available to you for review at no cost at any time.

I acknowledge that I have received the Payment and Notice of Privacy Practices for iCare EyeCare

Signature: _____ Date: _____
(Patient Signature, Parent or Guardian if the patient is a minor)

Medical Records, Forms and Prescriptions

Request for medical records must be received via fax (205) 328-1744, by mail or email (morrisaveeyecare@bellsouth.net). The fee for records is $50.00. Records will be released if the account has a zero balance. **Any balance due from the patient must be received before medical records are released.**

Medical forms, driver's license forms and school forms will be completed and released if the account has a zero balance. **Any balance due from the patient must be received before medical records are released.**

Prescription will be completed, released and refilled if the account has a zero balance. **Any balance due from the patient must be received before prescriptions are released and or refills approved.**

I understand the above paragraphs and agree to the terms and conditions.

Signature: _____ Date: _____
(Patient Signature, Parent or Guardian if the patient is a minor)

Payment Policy of iCare EyeCare DBA: Morris Avenue Eyecare

The best doctor-patient relationships are maintained when there is a complete understanding of the treatment/materials provided and the fees charged for those services and/or materials. Please feel free to discuss the fees for any services and/or materials at any time with the doctors or staff.

The payment policy of ***iCare Eyecare*** is full payment is due for services rendered and materials provided on the same day unless other arrangements are made prior to the date of services or provision of materials. If you have insurance, co-payments, all non-covered charges form the visit, and payments towards your deductible are due at the time of service.

Routine Vision Exam vs. Medical Office Visit

A medical office visit may be needed in order to diagnose and treat acute eye infections, eye injuries, eye diseases (such as diabetes, cataracts, glaucoma among others) and allergies. These visits do not fall under routine vision care since they are more complex and require more time to treat. Sometimes it is not possible to know before hand if an examination qualifies as routine vision care or a medical office visit. These fees are different depending on the amount of testing required as well as the complexity of the problem.

EyeWear/Vision Insurance vs. Medical insurance

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. EyeWear/Vision insurance is designed for routine examinations to determine a prescription for glasses or contact lenses. It is not available to treat complex medical conditions and/or diagnoses and does not require a detailed examination of the retina.

When a medical diagnosis or condition is present (such as diabetes, cataracts, glaucoma, red eyes or other eye diseases) it is necessary to file the visit with your major medical insurance and the co-pays for that insurance will be due as well as any non-covered service.

If your appointment is for a routine examination and you have diabetes, the standard of optometric care includes fundus photography. **These photographs will be filed to your major medical insurance company and not your eyewear/vision insurance carrier.** We do not know if your major medical insurance company will pay for these services or if they will be applied towards your deductible. **You will receive an explanation of benefits from your major medical insurance company advising what they paid and what you owe our office.**

Our office does not make these rules. The insurance carriers themselves define them. There is no way to know prior to the examination which type of insurance our office will be able to file for you. We accept most major medical insurance plans for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, full payment is due at the time of service and we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know prior to your exam.

For those patients with medical/vision insurance, your insurance coverage is a contract between you and your insurance company. It is your responsibility to determine what is covered under your particular insurance plan and to verify any deductibles, co-insurance or copays. We cannot be held responsible for any misunderstandings between you, the patient, and your insurance company. You will be responsible for any portion of your account not paid by your insurance coverage.

I have read this disclosure. I understand the above paragraphs and agree to the terms and conditions.

Signature: _____ Date: _____

(Patient Signature, Parent or Guardian if the patient is a minor)

Collections, Cell Phone and Email Policy

The following document is the policy of the collection agency:

Our office will make two attempts at collecting balances due. If payment in full or payment arrangements have not been made thirty days after our second attempt, your account will be turned over to a collection agency. **MEDICAL RECORDS, PRESCRIPTIONS AND ANY AND ALL FORMS WILL NOT BE RELEASED, COMPLETED, FILLED OR REFILLED UNTIL YOUR ACCOUNT IS RELEASED FROM COLLECTION AND HAS A ZERO BALANCE.**

EXPRESS PRIOR TO CONSENT TO CONTACT CONSUMER BY CELL PHONE AND/OR EMAIL: You agree, in order for us to service your account or to collect monies you may owe, iCare EyeCare and/or our agents, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

AGREEMENT TO PAY: I, the undersigned, accept the fees charged as a legal and lawful debt and agree to pay said fees, including any and all costs of collection, attorney fees and or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

I have read this disclosure. I understand the above paragraphs and agree to the terms and conditions.

Signature: _____ Date: _____

(Patient Signature, Parent or Guardian if the patient is a minor)