Notice of Privacy Practice

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.

THIS NOTICE IS EFFECTIVE 09/28/04 UNTIL FURTHER NOTICE.

Right to Notice As a patient: You have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), **Southern Vision Care** can use your protected health information for treatment, payment and health care operations. a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. b) Payment - We may use and disclose your health information to obtain payment for services we provide you. c) Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. -You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: Southern Vision Care is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information: For further information about **Southern Vision Care's** privacy policies, please contact **Dr. Mark Shirey** at the following address or phone number: Southern Vision Care 7921 Tanner Williams Rd. Suite H Mobile, AL 36608 (251) 634-2144

Acknowledgement of Receipt:

I acknowledge that I received a copy of **Southern Vision Care's** Notice of Privacy Practices. Date: _____

Signature: _____ Patient name: _____

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. Vision coverage is mainly designed to determine a prescription for glasses, help pay for eyeglasses or contact lenses, and to evaluate the health of their eyes. It is not designed or equipped to deal with medical conditions, diagnoses, and/or treatment plans.

When a medical diagnosis or condition is present (such as high blood pressure, diabetes, or an eye disease such as infections, dry eyes, allergy, and cataracts, to name just a few) it is necessary to file the claim for your visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. Vision insurance does not cover medical eye problems, just as medical insurance does not cover routine vision problems. Our office does not make these rules; they are defined by the insurance carriers themselves.

There is no way to know prior to the examination which type of insurance will apply or with whom our office will be able to file a claim for you. We make every effort to be a provider on every major carrier for your convenience and we will file those claims for you when there is a medical problem. In the event that we do not take your major medical/vision insurance, 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.

I understand the paragraph above and authorize Southern Vision Care to file a claim with my insurance.

_____ _____

Name Signature/Date

**********Adding Collection Fees To Account Balances:**********

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to said fee, including any/all collection agency fees, (33.33%), attorney fee and/or court costs, if such be necessary. I waive now and forever my rights of exemption under laws of the constitutions of the State of Alabama and any other State.

**********Consent To Contact Debtors On Their Cell Phones:**********

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER By CELL PHONE:

You agree, in order for us to service your account or to collect monies you may owe, Southern Vision Care and/or 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 any e-mail, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Southern Vision Care, it employees and /or agents may contact me/us as described above

_____ _____

Name Signature/Date