Northwest Eye Surgeons

Patient Registration Form

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE

FIRST NAME* | LAST NAME*

DATE OF BIRTH* | AGE* | SEX* | SOCIAL SECURITY NUMBER*

HOME PHONE NUMBER* | CELL PHONE NUMBER | PREFERRED PHONE NUMBER | E-MAIL ADDRESS

ADDRESS*

CITY* | STATE* | ZIP CODE* | MARITAL STATUS*

OCCUPATION* | EMPLOYER'S NAME* | IS THIS EXAM DUE TO A WORK RELATED ACCIDENT?*

Yes No

EMPLOYER'S ADDRESS*

CITY* | STATE* | ZIP CODE*

HOW DID YOU HEAR ABOUT OUR PRACTICE?* | PREFERRED LANGUAGE*

WHAT IS YOUR RACE/ETHNICITY?*

Asian African-American Caucasian Hispanic Middle Eastern Prefer not to disclose

IS THERE ANYONE, OTHER THAN YOUR DOCTOR, WITH WHOM WE CAN DISCUSS YOUR PRIVATE HEALTH INFORMATION? FOR EXAMPLE, YOUR FAMILY MAY HAVE QUESTIONS REGARDING YOUR CARE, BILLING OR APPOINTMENTS.*

Yes No

FAMILY CONTACT'S NAME* | PHONE NUMBER* | HOW IS THIS PERSON RELATED TO YOU?

northwesteyesurgeons.com PHONE 614.451.7550 FAX 614.451.8642

If you did not provide a contact in the previous question, please provide Emergency Contact Information.

EMERGENCY CONTACT'S NAME **PHONE NUMBER** **HOW IS THIS PERSON RELATED TO YOU?**

Physician Information

This section is required for correspondence with your Primary Care Physician.

PRIMARY CARE PHYSICIAN'S NAME* **PHONE NUMBER**

ADDRESS

CITY **STATE** **ZIP CODE**

Vision Insurance

DO YOU HAVE SPECIFIC VISION INSURANCE, SUCH AS VISION SERVICE PLAN?*

Yes No

NAME OF VISION INSURANCE PLAN **POLICY NUMBER**

POLICY HOLDER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

Medical Insurance

This section must be completed in addition to providing a current insurance card at the time of your visit. We cannot file a claim without an insurance card.

DO YOU HAVE HEALTH INSURANCE?*

Yes No

Primary Insurance

NAME OF INSURANCE PLAN **POLICY NUMBER**

POLICY HOLDER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

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Secondary Insurance

NAME OF INSURANCE PLAN **POLICY NUMBER**

POLICY HOLDER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

Financial Responsibility

If the patient is a minor (under the age of 18) or someone other than the patient has legal responsibility, (i.e. attorney, trustee, POA, or former spouse) please provide us with a copy of the appropriate court order and/or the name and certificate number of the appropriate health insurance, and complete the following:

FAMILY CONTACT'S NAME* **PHONE NUMBER*** **HOW IS THIS PERSON RELATED TO YOU?**

ADDRESS

CITY **STATE** **ZIP CODE**

SIGNATURE **DATE**

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Signature on File, Assignment of Benefits, and Financial Agreement

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Northwest Eye Surgeons (NWES), for services furnished me by NWES. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. NWES accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere in other approved forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made in my behalf to NWES, if possible or otherwise to me.

3. REFERRAL & CO-PAYMENT: I understand if I am covered by an HMO (Including Medicare HMO) that requires a REFERRAL from a Primary Care Physician, I am responsible for obtaining that referral and assuring its arrival in this office. Northwest Eye Surgeons is not responsible for contacting the Primary Care Physician or obtaining that referral. If my referral is not in this office at the time of my appointment, I will be asked to sign a Waiver of Insurance Liability, making the patient financially responsible for all charges incurred. These charges are to be paid at the time of service. All co-payments are required at the time of service. Failure to do so can be a violation of my insurance coverage agreement.

4. RELEASE OF INFORMATION: NWES may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to NWES for reimbursement for services rendered, and (2) any health care provider for continued patient care. NWES may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy if this authorization may be used in place of the original.

5. OTHER INSURANCE: Northwest Eye Surgeons participates in a variety of insurance contracts. I understand I am responsible for contacting my insurance carrier directly for information on covered services or providers. I understand that I am obligated to pay the full charges of all services rendered to me by NWES if I belong to a plan that NWES is not contracted with.

6. NON-COVERED SERVICES: I understand that NWES' contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with NWES to obtain necessary health care service plan authorizations.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by NWES, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to NWES for payment. All benefits under the patient's insurance policies, or any other party liable to the patient, are hereby assigned to Northwest Eye Surgeons. I also understand that by signing below I agree to pay any and all charges on my account that are not covered or have been deemed Patient Responsible by my insurance company. These charges may include but are not limited to co-payments, deductibles, coinsurance, and vision services (such as REFRACTIONS and contact lens services). I understand that if I fail to provide valid, current insurance information to Northwest Eye Surgeons before the filing limit, I am responsible for all charges incurred.

SIGNATURE **DATE**

For Office Use Only

DATE UPDATED	INITIALS	DATE UPDATED	INITIALS

Northwest Eye Surgeons

Personal & Family Medical History

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME*

LAST NAME*

Please check any medical conditions which apply

Cardiovascular	FAMILY	PERSONAL
CONGESTIVE HEART FAILURE		
CORONARY HEART DISEASE		
HEART ATTACK		
HIGH BLOOD PRESSURE		
Endocrine		
DIABETES (TYPE I OR II)		
THYROID PROBLEMS		
HIGH CHOLESTEROL		
Pulmonary		
ASTHMA		
COPD		
Genitourinary		
PROSTATE PROBLEMS		
ERECTILE DYSFUNCTION		
Eye History		
MACULAR DEGENERATION		
GLAUCOMA		
CATARACTS		
OTHER SIGNIFICANT EYE ISSUE		

Gastrointestinal	FAMILY	PERSONAL
ULCERS		
GERD		
COLITIS		
Rheumatology		
OSTEOARTHRITIS		
RHEUMATOID ARTHRITIS		
LUPUS		
Neurology		
STROKES		
Reproductive		
REPRODUCTIVE PROBLEMS		

Other Significant Health Issues

Please List Any Major Surgeries or Hospitalizations You Have Had

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DATE UPDATED	INITIALS	DATE UPDATED	INITIALS

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NORTHWEST EYE SURGEONS

Patient Medication List & Ophthalmological History

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME*

LAST NAME*

MEDICATIONS AND EYE DROPS (INCLUDING OVER THE COUNTER AND HERBAL)*

HAVE YOU EVER TAKEN MEDICATION FOR PROSTATIC OR URINARY ISSUES?* *(e.g. Flomax)*

Yes No

IF YES, PLEASE LIST MEDICINES

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?*

Yes No

IF YES, PLEASE LIST MEDICATIONS AND REACTIONS

Ophthalmological History

PLEASE LIST EYE INJURIES

PLEASE LIST EYE SURGERIES

PLEASE LIST LASER EYE TREATMENTS

Have you ever had any of the following:

CATARACTS

SINUS INFECTION

AMBLYOPIA *"Lazy Eye"*

VITREO RETINAL
floaters, retinal detachment, diabetic retinopathy, macular degeneration

NEVUS
conjunctiva, choroid, iris, eyelid, other

GLAUCOMA

DOUBLE VISION, PRISM IN GLASSES

CORNEA
dry eye, scar, keratoncous, Fuch's dystrophy

CONTACT LENS

OTHER EYE PROBLEMS

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Explanation of Medical vs. Routine

Please complete each area. Fields marked with an asterisk* are required.

TODAY'S DATE*

FIRST NAME* **LAST NAME***

Many patients have Routine Eye Exam benefits as part of their health insurance or with a separate vision plan. When you have medical coverage and routine coverage, which plan should be billed for your visit? Actually, your insurance company dictates it depending upon the reason for the visit.

Medical Benefits are billed if you are here for medical care, much the same as when you visit a cardiologist for an evaluation or follow-up for a heart condition. Medical care would address such items as:

- Evaluation of an ocular disease, you have been diagnosed with glaucoma, cataract, retina disease; or
- Complaint of red eyes, tearing, burning, floaters, flashes of light; or
- Follow up of an existing condition, such as diabetes, Plaquenil medication for autoimmune disease; or
- Ancillary testing is needed, such as visual field, OCT, etc.

Routine Vision Benefits are billed if you are having a routine visit. Routine visits would address such items as:

- A healthy eye exam, much the same as a "routine physician"; or
- An eyeglass prescription is updated

These definitions are based on the guidelines of your insurance company and vision plans. Northwest Eye Surgeons is contractually obligated to follow them. Northwest Eye Surgeons makes every effort to submit claims correctly to ensure that we are in compliance with our contracted insurance carriers and vision plans AND that you do not receive unexpected medical bills for uncovered services.

Please let us know if you would like any additional clarification on this issue.

SIGNATURE **DATE**

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DATE UPDATED	INITIALS	DATE UPDATED	INITIALS

NORTHWEST EYE SURGEONS

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Review of System

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME*

LAST NAME*

Please check any symptoms you are having today

Allergic

- HIVES
- SEASONAL ALLERGIES

Cardiovascular

- PALPITATIONS
- PAIN

Constitution

- FEVER
- WEIGHT LOSS

ENT

- HEARING LOSS
- RUNNY NOSE
- SINUS INFECTION

Endocrine

- INCREASED THIRST
- HAIR LOSS

Eyes

- BLURRED VISION
- FLOATERS
- PAIN

Gastrointestinal

- NAUSEA
- REFLUX
- HEARTBURN
- DIARRHEA

Genitourinary

- FREQUENT URINATION

Hematologic

- BRUISE
- BLEED EASILY

Skin/Integumentary

- RASH
- SORES

Musculoskeletal

- BACK PAIN
- JOINT PAIN

Neurologic

- DIZZINESS
- WEAKNESS
- HEADACHE

Psychiatric

- CHANGE IN MOOD
- DEPRESSION
- ANXIETY

Respiratory

- COUGH
- WHEEZING
- SHORTNESS OF BREATH

Social History Frequency

ALCOHOL

Never   Occasional   Daily   Heavy

TOBACCO

Never   Quit smoking   Occasional   Daily smoker

RECREATIONAL DRUGS

Yes   No

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DATE UPDATED	INITIALS	DATE UPDATED	INITIALS

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Northwest Eye Surgeons, Inc. Notice of Privacy Practices

Effective Date: September 23, 2013

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.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the practices of Northwest Eye Surgeons, Inc. ("NWES") and the practices that will be followed by all NWES workforce members who handle your medical information.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

NWES understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care which are received or created by NWES.

This Notice will tell you about the ways in which NWES may use and disclose medical information about you. Your medical information, also referred to as "protected health information" or "PHI," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations NWES has regarding the use and disclosure of your protected health information. We are required by law to:

- make sure that medical and other information that identifies you (protected health information) is kept private;
- give you this Notice of our legal duties and privacy practices with respect to protected health information about you; and
- follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By becoming a patient of NWES, you are giving consent for NWES to use your protected health information for certain activities, including Treatment, Payment and other Health Care Operations. Sometimes, you may hear these three activities referred to as "TPO."

TREATMENT

We may use and disclose protected health information about you so that NWES and its medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present illness or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care.

PAYMENT

We may also use and disclose protected health information about you so that we may be paid for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you.

HEALTH CARE OPERATIONS

We may also use and disclose protected health information about you for NWES health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care. For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in Ohio.

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OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

YOUR AUTHORIZATION.

We will not use or disclose your PHI for any purpose other than treatment, payment and health care operations unless you have signed a form authorizing the use or disclosure with, the exceptions of the situations outlined in this notice. If you authorize us to use or disclose protected health information about you, you may revoke that permission, in writing, at any time, and we will no longer use or disclose protected health information about you for the reasons covered by your authorization. You understand that we are unable to take back any uses or disclosures we have already made with your permission, and that we are required to retain our records of the medical treatment or other services that we have provided to you.

The following uses of your protected health information may be made without any additional authorization from you, unless otherwise noted. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by NWES are only those which are permitted under the law):

BUSINESS ASSOCIATES

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, billing, legal services, etc. At times, it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, those business associates are required to appropriately safeguard the privacy of your information.

MARKETING

We must receive your authorization for any use or disclosure of PHI for marketing, except if the communication is in the form of a face-to-face communication made to you personally; or a promotional gift of nominal value provided by NWES. It is not considered marketing to send you information related to your individual treatment, case management, care coordination or to direct or recommend alternative treatment, therapies, health care providers or settings of care. These may be sent without written permission. If the marketing is to result in financial remuneration to NWES by a third party, we will state this on the authorization.

FUNDRAISING

We may contact you to donate to a fundraising effort for or on our behalf. You have the right to “opt-out” of receiving fundraising materials/communications and may do so by calling (614) 451-7550 and informing us of your wish not to receive such materials. NWES will not condition treatment or payment on your choice with respect to the receipt of fundraising communications.

APPOINTMENT REMINDERS

We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing at 2250 North Bank Drive, Columbus, OH 43220. We will accommodate all reasonable requests.

OTHERS INVOLVED IN YOUR HEALTH CARE

We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person’s involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

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EMERGENCY SITUATIONS

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this Notice as soon as reasonably practicable after the delivery of treatment.

HEALTH-RELATED BENEFITS OR SERVICES

From time to time, NWES may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

REQUIRED BY LAW

We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

PUBLIC HEALTH ACTIVITIES

We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

COMMUNICABLE DISEASES

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

HEALTH OVERSIGHT ACTIVITIES

We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

ABUSE OR NEGLECT

We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with relevant state law.

FOOD AND DRUG ADMINISTRATION

We may disclose your protected health information to a person or company required by the Food and Drug Administration (FDA) to report adverse events, product defects or other problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements; or to conduct post-market surveillance, as required.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court order or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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LAW ENFORCEMENT

We may release protected health information if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures relating to individuals who are Armed Forces personnel, to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION

We may disclose protected health information about you to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties required by law. We may also disclose protected health information about you to a funeral director in order to permit the funeral director to carry out legal duties, and may do so if death is reasonably anticipated. Your protected health information may also be disclosed for certain organ donations to which you may have agreed.

RESEARCH

We may disclose your protected health information to researchers when their research has been approved and protocols have been established to ensure the privacy of your information. We may also disclose a limited set of your information, as allowed under the law, for research purposes.

CRIMINAL ACTIVITY

We may disclose your protected health information, consistent with federal and Ohio laws, if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or if it is necessary for law enforcement authorities to identify or apprehend an individual.

WORKERS' COMPENSATION

We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

EMPLOYER

We may release your PHI to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer.

SALE OF PHI

We must receive your authorization for any disclosure of your PHI which is a sale of PHI. Such authorization will state that the disclosure will result in remuneration to NWES.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS

Federal law and regulations protect the confidentiality of alcohol and drug program records. To the extent PHI in our possession contains information on your alcohol or drug use, it may not be disclosed without 1) your written authorization; 2) a court order; or 3) unless the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation. Federal law or regulations do not protect any information about a crime committed by you at our facility or about any threat to commit a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

CONFIDENTIALITY OF PSYCHOTHERAPY NOTES

We must receive your authorization for any use or disclosure of psychotherapy notes, except: for use by the originator of the psychotherapy notes for treatment or health oversight activities; for use or disclosure by NWES for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; for use or disclosure by NWES to defend itself in a legal action

or other proceeding brought by you; to the extent required to investigate or determine NWES' compliance with the HIPAA regulations; to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law; for health oversight activities with respect to the oversight of the originator of the psychotherapy notes; for disclosure to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

CONFIDENTIALITY OF HIV TEST OR DIAGNOSIS OF AIDS OR AIDS-RELATED CONDITION

Ohio law requires that we have your authorization or a court order before disclosing the results of an HIV test or diagnosis of AIDS or AIDS- related conditions.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU:

RIGHT TO ACCESS

You have the right to inspect and copy protected health information that may be used to make decisions about your medical care. Usually this right includes both medical and billing records. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy your information may only be denied in very limited circumstances and you have a right to request that any such denial be reviewed. In addition, you have a right to access your PHI in electronic format upon request, when available.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request that we restrict the use and disclosure of your PHI for treatment, payment and health care operations. We are not required to agree to your request in all circumstances. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You have the right to require restrictions on disclosure of your PHI to a health plan where you paid out of pocket, in full, for items or services and we are required to honor this request. To request restrictions, you must make your request in writing to 2250 North Bank Drive, Columbus, OH 43220. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

RIGHT TO CONFIDENTIAL COMMUNICATIONS

You also have the right to request to receive private health information communications by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to 2250 North Bank Drive, Columbus, OH 43220. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO AMEND

If you feel that the protected health information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Only the health care entity (e.g., doctor, hospital, clinic, etc.) that created your protected health information is responsible for amending it. We are not obligated to make all requested amendments but will give each request careful consideration. If an amendment you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Any request to amend must be in writing to 2250 North Bank Drive, Columbus, OH 43220.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have a right to an accounting of disclosures of your protected health information, for purposes other than treatment, payment or health care operations by NWES or any of the people or companies who perform treatment, payment or health care operations on our behalf. To request this list of disclosures we made of protected health information about you, you must submit a request in writing to 2250 North Bank Drive, Columbus, OH 43220. Your request must state a

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time period which may not be longer than six (6) years prior to the date of your request. Your request should indicate the form in which you want the list (for example, on paper or electronically).

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time.

To learn more about these procedures, or to make any of these requests, you should contact Rebecca Dunaway at (614) 451-7550.

CHANGES TO THIS NOTICE

NWES reserves the right to change this notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you, as well as any information we create or receive in the future.

COMPLAINTS

If you believe your privacy rights have been violated or that NWES has not followed this policy, you may file a complaint with NWES or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to 2250 North Bank Drive, Columbus, OH 43220. You will not be penalized for filing a complaint.

BREACH NOTIFICATION

In the event of any Breach of Unsecured PHI, NWES shall fully comply with the HIPAA Breach Notification Rule, which will include notification to you of any impact that Breach may have had on you and/or your family member(s) and actions NWES undertook to minimize any impact the Breach may or could have on you.

QUESTIONS?

If you have any questions regarding this notice, please contact Rebecca Dunaway at (614) 451-7550.

NORTHWEST EYE SURGEONS, INC. PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

NAME **SIGNATURE** **DATE**

FOR OFFICE USE ONLY

Patient refused or unable to sign

COMMENTS

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