



CENTER
FOR
EXCELLENCE
IN EYE CARE

PATIENT INFORMATION

PRIMARY LANGUAGE SPOKEN _____ DATE (FECHA) _____ ACCOUNT # _____

NAME (NOMBRE): _____ SEX (SEXO) _____

MARITAL STATUS (ESTADO CIVIL) _____ DATE OF BIRTH (FECHA DE NACIMIENTO) _____ AGE (EDAD) _____

SOCIAL SECURITY NUMBER (NUMERO DE SEGURO SOCIAL) _____

PHONE (TELÉFONO) HOME (CASA) _____ WORK (TRABAJO) _____ CELL (CELULAR) _____

ADDRESS (DIRECCIÓN) _____

CITY (CIUDAD) _____ STATE (ESTADO) _____ ZIP CODE (CÓDIGO POSTAL) _____

PERSON RESPONSIBLE FOR BILL _____
(PERSONA RESPONSABLE POR LA CUENTA)

OCCUPATION (OCUPACIÓN) _____ WORK PHONE (TELÉFONO DEL TRABAJO) _____

EMPLOYER (EMPLEADOR) _____

ADDRESS (DIRECCIÓN) _____

PATIENT'S SPOUSE OR PARENT (IF MINOR) _____
(ESPOSO (A) O PADRES (SI ES MENOR))

REFERRED BY (REFERIDO POR) _____ PHONE (TELÉFONO) _____

FAMILY PHYSICIAN (MÉDICO FAMILIAR) _____ PHONE (TELÉFONO) _____

INSURANCE CARRIER NAME (NOMBRE DEL SEGURO) _____

NAME AND SOCIAL SECURITY NUMBER OF THE SUBSCRIBER _____
(NOMBRE Y NÚMERO DE SEGURO SOCIAL DEL ASEGURADO)

ALLERGIES (ALERGIAS) _____

EMERGENCY CONTACT: NAME _____ PHONE _____ RELATIONSHIP _____

MAY WE LEAVE A MESSAGE IN YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE? N/A ___ YES ___ NO ___
(¿PODEMOS DEJARLE UN MENSAJE EN SU MÁQUINA TELEFÓNICA Ó CORREO ELECTRÓNICO?)

MAY WE CONTACT YOU AT WORK? (¿PODEMOS LLAMARLE AL TRABAJO?) N/A ___ YES ___ NO ___

MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMBER? YES ___ NO ___
(¿NOS AUTORIZA A DISCUTIR INFORMACIÓN MÉDICA CON SU ESPOSO /A – Ó ALGUN FAMILIAR?)

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to the Center For Excellence in Eye Care for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

(El (La) suscrito (a) autoriza que, toda la información médica necesaria para procesar cualquiera de mis reclamos a mi compañía de seguros sea puesta a disposición de ésta. Así mismo autorizo el pago de mis beneficios médicos directamente al Center For Excellence in Eye Care. Entiendo y acepto que, independiente de mi condición de asegurado (a), soy totalmente responsable de mi cuenta por los servicios profesionales recibidos en este centro. Si acaso esta cuenta fuese enviada a un servicio de cobranzas, todos los gastos que se originen de este recurso legal son también de mi responsabilidad). El/la suscrito/a consiente que al firmar como padre, esposo/a, fiador, guardian o paciente, asume la responsabilidad y obligación por cualquier balance pendiente que derive a causa de tratamiento médico a dicho paciente. En caso de que la cuenta fuese referida a un abogado, el/la suscrito/a pagara dichas cuentas legales y asumira costos de colección.

SIGNATURE (FIRMA) _____ **NAME (NOMBRE)** _____

PLEASE PRINT NAME (por favor use letra de molde)

PLEASE SUBMIT YOUR INSURANCE CARDS SO THAT WE MAY MAKE A COPY FOR OUR RECORDS.

(POR FAVOR ENTRÉGUENOS SU TARJETA DE SEGURO PARA HACER UNA COPIA PARA NUESTRO ARCHIVO)

PLEASE READ, COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

(POR FAVOR LEA, COMPLETE Y FIRME EL REVERSO DE ESTA HOJA)

TO OUR PATIENTS ABOUT YOUR INSURANCE

The health insurance policy that you have is a personal contract that you have with your insurance company. We are simply physicians, and we do our very best to provide excellent service in a caring environment. We deserve to be paid for this service regardless of whether your insurance covers this or not. We are not employed by your company, nor do we make policy decisions for your company. Many patients are confused by their insurance company's coverage of **vision care**. Many policies will only cover a "medical diagnosis". This means that if the doctor finds something medically wrong at the time of his examination, some or all of the cost of this examination may be covered by the insurance company, as long as your company considers it "medical". However, if the examination is **normal** or has a "**vision**" diagnosis such as myopia, amblyopia, hyperopia, astigmatism, headaches or asthenopia, your insurance will not pay for your examination.

Since we have no way of knowing in advance what the doctor will find, we cannot tell you in advance whether your visit will be covered or not, and you may be responsible for this visit.

Some companies require that you have a referral from your **PRIMARY PHYSICIAN**, and it is your responsibility to obtain that referral. If you wish to be seen without a referral, you will be responsible for payment at the time of your visit.

It is the patient's responsibility to know and understand his/her own individual policy. We are involved with so many different companies that we cannot be interpreters of the policies for each patient. Thank you for your cooperations and patience.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND

SIGNATURE _____ **DATE** _____

A NUESTROS PACIENTES CON RESPECTO A SU SEGURO MEDICO

La póliza de seguro que Ud. tiene es un contrato personal entre Ud. y su Compañía de seguros. Nosotros somos solamente médicos brindándoles nuestro mejor cuidado en un ambiente de respeto y de genuino interés por su bienestar. Merecemos que nuestros servicios sean remunerados independientemente si están cubiertos o no por su póliza actual. No estamos empleados por su Compañía ni tomamos decisiones con respecto a su póliza dentro de la misma. **Muchos pacientes se confunden con la forma en que su compañía de seguros cubre el cuidado de su visión.**

Muchas pólizas sólo admiten los gastos generados por una condición de enfermedad ocular, o sea un diagnóstico médico. Esto significa que si su doctor encuentra patología ocular durante su examen, parte o toda su cuenta será cubierta por su seguro, si su seguro determina que ésa fue la razón de su consulta. Sin embargo, si el examen demuestra que Ud. esta normal de la vista, o tiene un diagnóstico visual tal como miopia, ambliopía, hipermetropía, astigmatismo, presbicia, cefaleas o astenopía su seguro no pagará por su examen oftalmológico.

Como no nos es posible predecir de antemano cual será el resultado del examen, tampoco podemos decirle de antemano si su consulta estará cubierta o no por su seguro, y Ud. podría ser responsable por el pago de esta consulta. Algunas Compañías requieren que Ud. sea referido pro su Médico Primario, y es su deber traer consigo este referido al momento de su consulta. Si Ud. desea ser atendido sin este requisito, Ud. será responsable de pagar al momento de su consulta.

Es la responsabilidad de cada paciente conocer y entender sus pólizas individuales. Nosotros trabajamos con un gran número de compañías aseguradoras, y no nos es posible actuar de intérpretes de las pólizas individuales de cada paciente.

Le agradecemos su cooperación y paciencia

HE LEIDO LO ANTERIOR Y LO HE ENTENDIDO COMPLETAMENTE

FIRMA _____ **FECHA** _____

NOTICE OF PRIVACY PRACTICES

Date of Last Revision: 5/2004

Effective Date: Immediately

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 APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE CENTER FOR EXCELLENCE IN EYE CARE, WHETHER MADE BY THE CENTER FOR EXCELLENCE IN EYE CARE OR AN ASSOCIATED FACILITY.

If you have any questions about this notice, please contact our office at (305) 598-2020
8940 North Kendall Drive, Suite 400E, Miami, FL 33176.

This notice describes our practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, physician assistants, registered nurses, technicians etc.);
- All areas of the Center For Excellence in Eye Care (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with the Center For Excellence in Eye Care;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Center For Excellence in Eye Care provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.
- provide you with a copy of any amendment to our Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- Medical Treatment. We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Or, if your family doctor has determined that you need to be seen by the Center For Excellence in Eye Care for ophthalmology care, we may send your family doctor a report of our diagnostic findings and our plan of treatment. Different areas of the Center For Excellence in Eye Care also may share medical information about you including your record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Center For Excellence in Eye Care who may be involved in your medical care after you leave the Center For Excellence in Eye Care; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).
- Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Center For Excellence in Eye Care, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Health Care Operations. We may use and disclose medical information about you so that we can run our practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

- Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.
- Appointment and Patient Recall Reminders. We may ask that you sign in writing at the Receptionists' Desk, a "Sign In" log on the day of your appointment with the Center For Excellence in Eye Care. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Center For Excellence in Eye Care or that you are due to receive periodic care from the Center For Excellence in Eye Care. This contact will be made by phone, in writing, or as specified by you during your initial visit.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of the Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

- Emergency Situations. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.
- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.
- Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of the Center For Excellence in Eye Care in any actual or threatened action.

- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at the Center For Excellence in Eye Care; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Center For Excellence in Eye Care to funeral directors as necessary to carry out their duties.
- Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current Notice in the Center For Excellence in Eye Care. The Notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Center For Excellence in Eye Care for treatment or health care services you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Center For Excellence in Eye Care or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center For Excellence in Eye Care, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

The Office Manager can be reached at this number: (305) 598-2020.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written Authorization, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your Authorization to use or disclose medical information about you, you may revoke that Authorization, in writing, at any time.

If you revoke your Authorization, we will no longer use or disclose medical information about you for the reasons covered by your written Authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THE CENTER FOR EXCELLENCE IN EYE CARE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Center For Excellence in Eye Care will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- **Right to Amend.** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Center For Excellence in Eye Care maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend or include information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Center For Excellence in Eye Care;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate:

- what information you want to limit;
 - whether you want to limit our use, disclosure or both; and
 - to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. 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 us to contact you.

- 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ Medical Record # _____

Date of Visit _____

My signature on this form acknowledges that I have received a copy of the Center For Excellence in Eye Care's Notice of Privacy Practices.

- The Center For Excellence in Eye Care has the right to change the terms of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.
- I understand that the Notice explains some of the ways in which the Center For Excellence in Eye Care may use or disclose my health information.
- The Notice also explains my rights with respect to my health information.

I am the patient or I am authorized to act on behalf of the patient for the reason described below.

Date _____
Patient's Signature _____

Date _____
Signature of Patient's Representative if
Patient is unable to sign _____

Relationship of Patient's Representative to Patient _____

TO BE COMPLETED BY HEALTH CARE PERSONNEL IF FORM WAS NOT SIGNED

1. Was the patient provided with a copy of the Center For Excellence in Eye Care's Notice of Privacy Practices? _____ YES _____ NO
2. Briefly describe efforts made to obtain the patient's Acknowledgement of Receipt of the Notice and explain why the patient was not able or willing to sign this form:

Date _____
Signature of Health Care Personnel _____