

# Medical History / Review of Systems

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Sex: **M**  **F**  Do you have Medicare? **Y**  **N**   
 Check if you DO NOT want to receive email from us.  
 Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Occupation / Employer / Parent or Guardian if patient is a child: \_\_\_\_\_  
 Who may we thank for referring you to us? \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

## MEDICAL HISTORY

Do you have any allergies to medications?  NO  YES If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, eyedrops, over the counter medications & home remedies):  
 \_\_\_\_\_  
 \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_  
 \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

Are you pregnant and / or nursing?  no  yes

Do you wear glasses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

## FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment/Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other Inherited Disease _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

## SOCIAL HISTORY

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes If yes, please describe:

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Do you use tobacco products?  no  yes If yes, type / amount / how often? \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type / amount / how often? \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type / amount / what type? \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  
 Chlamydia  Tuberculosis

## REVIEW OF SYSTEMS

Do you currently, or have you ever had any **chronic** problems in the following areas?

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
<b>GENERAL / CONSTITUTIONAL</b>				<b>EARS, NOSE, MOUTH, THROAT</b>			
Fever, Weight Loss / Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies / Hay Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>SKIN</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>NEUROLOGICAL</b>				Runny Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Post-nasal Drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dry Throat / Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distorted Vision / Halos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>GASTROINTESTINAL</b>			
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>GENITOURINARY</b>			
Excess Tearing / Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Genitals/ Kidney / Bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glare / Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>BONES / JOINTS / MUSCLES</b>			
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sties or Chalazion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flashes / Floaters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
Tired Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>ENDOCRINE</b>				Bleeding Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid / Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>PSYCHIATRIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

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Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Catherine K. Kennedy, O.D. • Patrick R. Serafine, O.D. • Pamela A. Evans, O.D. • Carolyn J. Kerr, O.D. • Wally El Hitamy, O.D.



## Financial Responsibility and Policy Sheet

Printed Patient Name: \_\_\_\_\_

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our Account Manager. We are dedicated to providing the best possible vision care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

**INSURANCE:** We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized **co-payment/co-insurance at the time of service.**

**HMO:** If an HMO patient follows the **referral or authorization guideline** before their visit to a specialist, medical necessity is established and the service is a covered service as determined by your insurance company.

**VISION PLANS:** Vision plans only reimburse for routine eye diagnoses. These can be thought of as examinations for vision anomalies. The doctor may uncover medical eye conditions during the course of the examination, and additional diagnostic and treatment procedures to deal with this condition will be billed to your medical insurance plan or may not be covered by either plan. **Any diagnostic or treatment procedures which are not covered by your vision plan, or your medical plan must be paid for by you.**

**ALL OTHER INSURANCES:** The **co-payment made at the front desk is for the visit only and is often considered for the time you spent with the doctor.** If you have any procedures performed during your visit to Arboretum Vision Care, the procedure co-payment, deductible or co-insurance most likely is **NOT** covered in the co-payment made at the front desk. Unless otherwise stated by your insurance company, all other insurances have co-payments, and or co-insurance, encounter fees, yearly deductibles, must meet medical necessity requirements and must be a covered service. **In other words, the amount you pay during your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, processed and paid your claim.**

Miscellaneous:

- You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform Arboretum Vision Care if a change in your insurance coverage occurs.
- If you have insurance coverage with a plan for which we do not have a prior agreement, you will be treated as a cash or private pay patient.
- In the event that your health plan or vision plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Services most often denied by insurance companies: refraction, visual fields, contact lens fitting. Please call your insurance company to verify coverage of these services. The customer service number is located on your card.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or legal guardian with custody for payment.

**Assignment of Benefits:**

I hereby assign all medical and vision benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan or vision plan, to issue payment check(s) directly to Arboretum Vision Care for vision and medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Consent for Treatment:**

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and or treatments prescribed by my doctor, his/her assistants or designee as is necessary in his/her judgment.

**Authorization to Release Information:**

I hereby authorize Arboretum Vision Care to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested vision/medical services from Arboretum Vision Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. In the event of default, I understand that Arboretum Vision Care may use an outside collection company and/or report returned checks to the Attorney General's office for the State of Texas.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that Arboretum Vision Care's records contain protected health information about me and as such, are highly confidential. When appropriate, this office may use medical records for non-treatment purposes (research, public health, and some operational activities).

\_\_\_\_\_ Initials acknowledge receipt of this office's **Notice of Privacy Practices**

We are occasionally asked for a contact lens prescription after a general eye examination or after the initial contact lens fitting visit. However, determining your exact contact lens prescription requires more specialized testing than is involved in a general eye examination and cannot be finalized until the contact lenses have been worn for a period of time to ensure that no lens design changes will be needed. A "fitting period" is needed, which includes successful adaptation and wearing of the contact lenses, as monitored by follow-up visits. After the completion of this "fitting period", which varies for each patient, and for each type of contact lens, we will release the final contact lens prescription upon request. If you have any questions about contact lenses, fees or prescription release, please ask any of the clinic staff, or doctors.

**ALL PRESCRIPTIONS FOR GLASSES AND CONTACT LENSES EXPIRE IN ONE YEAR, AND WILL NOT BE FILLED THEREAFTER.**

I hereby confirm that the above information is correct to the best of my knowledge. I also acknowledge the prescription will not be released after one year and that I have informed this office of all my vision insurance coverage. I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## **PATIENT INFORMED CONSENT FOR / REFUSAL OF PUPIL DILATION**

I understand the doctors of Arboretum Vision Care recommend it to more thoroughly evaluate the internal health of my eyes. Without dilation, serious eye diseases, such as diabetes, retinal detachment or malignant tumors (which can result in blindness, loss of an eye, or even death) could be present and not seen by the doctor. I understand there is not an alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions of my optometrist, Arboretum Vision Care and their employees, officers, directors and agents. I also understand that if my medical history warrants dilation, my doctor has the authority to insist on the procedure in order to continue with the examination.

Please check one:     I agree to dilation today.     I refuse the dilation.  
                                  I will be responsible for rescheduling my dilation.

I hereby confirm that the above information is correct to the best of my knowledge.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature: \_\_\_\_\_

# Arboretum Vision Care

## Notice of Privacy Practices

**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.**

If you have any questions about this Notice please contact: Catherine K. Kennedy, O.D., or Patrick R. Serafine, O.D.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website at <http://www.arboretum-visioncare.com>, calling the office at (512) 345-5641 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **1. Uses and Disclosures of Protected Health Information**

#### Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your optometrist to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your optometrist will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your optometrist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the optometrist's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the optometrist's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose protected health information to other optometrists who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to an optometrist to whom you have been referred to ensure that the optometrist has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another optometrist or health care provider (e.g., a specialist or laboratory) who, at the request of your optometrist, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your optometrist.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a vision examination may require that your relevant protected health information be disclosed to the health plan to obtain approval for the optometric services.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support

the business activities of your optometrist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of technicians, licensing, marketing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to technician trainees that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your optometrist. We may also call you by name in the waiting room when your optometrist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, or to inform you that contact lenses are ready to pick up at our office. We will send you a postcard to remind you of your annual visit. We may also send you information about new services or products, based upon your private health information.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, contact lens vendors) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

#### Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your optometrist or the optometrist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your optometrist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, 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 health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may 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.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your optometrist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your optometrist or another optometrist in the practice is required by law to treat you and the optometrist has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your optometrist or another optometrist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication

barriers and the optometrist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

#### Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by 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, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating 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:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, 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 that is 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 the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

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

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

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

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose

your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your optometrist created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, 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 requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your optometrist and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your optometrist is not required to agree to a restriction that you may request. If optometrist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your optometrist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your optometrist. You may request a restriction by writing to Catherine K. Kennedy, O.D. or Patrick R. Serafine, O.D. We will respond, as required by Texas Law, within fifteen (15) business days.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your optometrist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described

in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Catherine K. Kennedy, O.D., or Patrick R. Serafine, O.D. at (512) 345-5641 or arboreye@swbell.net for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

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