NOTICE OF PRIVACY PRACTICES

Beach Vision Center An Optometric Corporation
Wayne Johnson, O.D., F.A.A.O.
A. Cory Thies, O.D.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment directly to Beach Vision Center and Optometric Corporation on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-150-0 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. The most common reason why we use or disclose your health information is for treatment, payment or health care operations. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, (we usually will not) ask you for special written permission. In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.

We may call or write to remind you of scheduled appointment, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

We will not make any other uses or disclosures of your health information unless you sign a written "Authorization form." The law gives you many rights regarding your health information. <u>You can</u>:
Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. Ask us to communicate with you in a confidential. Ask to see or to get photocopies of your health information. Ask us to amend your health information if you think that it is incorrect or incomplete. Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read/received a copy of (Wayne Johnson, O.D., F.A.A.O./ A. Cory Thies, O.D.) <u>Notice of Privacy Practices</u> and <u>Insurance Signature On File</u> form. (Please check box ☐ if you wish to obtain copy of this form).

Patient Name: (Please Print)_____

(Signature) _____Dated: _____