NOTICE OF PRIVACY PRACTICES
Effective date of notice: November 14, 2005

Robert R. Szeliga, O.D.
5328 Main Street
Spring Hill, TN 37174
931-489-1950
FAX: 931-489-1953
EMAIL: info@springhilleyecare.com
Office Contact: Dr. Szeliga

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.

At Spring Hill Eyecare, PLLC 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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. By law we are not required to receive your permission for these purposes. Examples of how we use or disclose information for **treatment purposes** are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another health care provider or clinic; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for **payment purposes** are: asking you about your health or vision care plans, or other sources of payment; verifying benefit enrollment and/or eligibility; preparing and sending bills or claims (either on paper or electronically); and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for **health care operations** are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information *inside our office* for these purposes without any special permission – it is not required by law. If we need to disclose your health information *outside of our office* for these reasons, we usually will not ask you for specific permission. We will ask for specific permission in the following situations: 1) marketing of products/services for which we may receive payment, 2) inclusion in medical studies or scientific research.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your specific permission. Not all of these situations will apply to our office or to you; some may never come up at our office at all. Such uses or disclosures are:

• when a state or federal law mandates that certain health information be reported for a specific purpose;
• for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
• disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
• uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
• disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
• disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim

of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
• disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
• uses or disclosures for health related research;
• uses and disclosures to prevent a serious threat to health or safety;
• uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
• disclosures of de-identified information;
• disclosures relating to worker's compensation programs;
• disclosures of a "limited data set" for research, public health, or health care operations;
• incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
• disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your immediate family or other caregivers (i.e. friends, legal representatives) who are helping you with your eye care.

APPOINTMENT REMINDERS

We may need to use your name, address, phone number, email and your clinical records to contact you with appointment reminders (for example, to remind you of scheduled appointments, to notify you when you have missed an appointment, or to remind you that it is time to make an appointment for continuing care), information about new products, treatment alternatives, or other health-related information that may be of interest to you. By signing this form, you are giving us authorization to contact you with these reminders and information. This contact may be made by phone, email, postal services, or private carriers (such as UPS or Federal Express). Products (for example, glasses or contact lenses) may be mailed directly to you. Mailed appointment reminders may be on a post card. If this contact is made by phone and you are not at home or work, a message may be left with others answering the phone or on your answering machine/voicemail.

OTHER USES AND DISCLOSURES

We **will not** make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you **do not** have to sign it. If you do not sign the authorization form, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:
• ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We **do not** have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address shown at the beginning of this Notice.
• ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address shown at the beginning of this Notice.
• ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part; however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address shown at the beginning of this Notice.
• ask us to amend your health information if you think that it is incorrect or incomplete. We are not required to agree with your request. If we agree, we will amend the information within 60 days from the written request. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal

statement that we may write. We **will not** amend health information falsely. Once your statement of position and/or our rebuttal is included in your health information; we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address shown at the beginning of this Notice.

• 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, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address shown at the beginning of this Notice.

• get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

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 we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site. We, at Spring Hill Eyecare, PLLC, are committed to the privacy of you health information and have established corporate policies (in addition to those outlined in this Notice) that guide the training of our providers and staff members in our Privacy Practices. Further, we make every endeavor to assure that our business associates are aware of our Privacy Practices and agree (whenever possible or required by law) to abide by these practices.

CONCERNS

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. We will make every attempt to investigate all legitimate reports. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

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.

SPRING HILL
EYECARE
PLLC
SH
See What You've Been Missing!

Robert R. Szeliga, O.D.
Virgilio Gozum, O.D.
5328 Main Street
Spring Hill, TN 37174

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Spring Hill Eyecare, PLLC has established a ***Privacy Policy*** and guidelines for ***Privacy Practices*** within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

☐ I have read, understand, and acknowledge the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC.

☐ I have elected not to read the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC, but have been provided with a copy today.

Patient name _____

Signature (or patient's representative)_____Date_____

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages, or to discuss financial/billing business, or to indicate other necessary contacts.

Please Initial

_____ Yes, I authorize the Practice to contact me at the contacts (phone #s/email) I have provided. I understand and authorize the practice to leave me a voicemail message if I am unavailable.

_____ No. I do not agree to these contacts. Do not leave a message.

The following people may have access to my personal health information:

Name:_____Relationship:_____

Name:_____Relationship:_____