NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ____________________, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Ophthalmology Partners Of Rockland
Soo Mee Pak M.D.

Notice Of Privacy Practice Acknowledgment

(After review of this document, please sign)

I, ____ hereby acknowledge that I have read and reviewed the "Notice of Privacy Practices" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations.

____

Signature of Patient or Patient's Representative (relationship)

Date: ____________________

SOO MEE PAK, M.D.

REFRACTION

REFRACTION IS THE EXAMINATION TO DETERMINE THE PRESCRIPTION FOR GLASSES. THIS PART OF THE EXAM IS CONSIDERED **VISION** NOT MEDICAL. DEPENDING ON YOUR INSURANCE COMPANY OR MANAGED CARE PROGRAM THIS SERVICE **MAY NOT** BE COVERED. THERE IS A SEPARATE CHARGE OF **$30.00** FOR REFRACTION DUE AT THE TIME OF SERVICE IF YOUR INSURANCE COMPANY DOES NOT COVER IT. IF YOU DO NOT WISH TO BE REFRACTED, NO PRESCRIPTION FOR GLASSES WILL BE GIVEN.

* PLEASE NOTE MEDICARE **DOES NOT** COVER REFRACTIONS*

PLEASE SIGN AND DATE ONE LINE ONLY

I have read the above notice and agree to pay for refraction if not covered by my insurance company.

______________________________ ________________

(Patient/guardian signature) (Date)

I **DO NOT** wish to have refraction; I understand I will not be given a prescription for
glasses.

______________________________ ________________

(Patient/guardian signature) (Date)

Ophthalmology Partners of Rockland
Soo Mee Pak, M.D.
365 South Main Street
New City, New York 10956

No Show Policy and Cancellation Policy

We understand that situations arise in which you must cancel your appointment. Therefore, if you must cancel your appointment we request that you provide more than 24 hours notice. This will enable another patient who is waiting for an appointment to be scheduled in that slot.

Patients who do not show up for their appointment without a call to cancel the appointment will be considered as a **NO SHOW.** The first time there is a "no show" your account will be noted that you failed to show up for your appointment and did not cancel. If there is a second "no show" a $25.00 fee will be billed to your account. This fee will need to be paid in full before scheduling any further appointments. Our practice firmly believes that good physician/patient relationship is based upon good communication. Thank you for your understanding and cooperation.

Please sign that you have read, understand and agree to this Cancellation and No show policy.

______________________________ ______________________________

Patient Name (Please Print) **Date**

____

Signature of Patient or Patient Representative