Acknowledgement and Agreement

I acknowledge receipt of the JSRC Financial Policy, and agree to all terms and conditions therein.

I acknowledge receipt of the Notice of Privacy Practices (Health Insurance Portability and Accountability)

I agree to allow access to my electronic prescription records as directed above.

I agree to the photograph policy above.

I acknowledge that the premises are under video surveillance as described above.

I agree to the referral to outside providers as above.

I agree to the release and assignment of benefits as described above.

I agree to treatment as described above.

I have read this form, my questions have been answered, and I understand and agree to its content.

_____

Patient Name

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, print name of Signatory

Relationship to Patient/Authority to Sign for Patient

Disclosure to designated person

I allow JSRC to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

_____ _____

Print Name Date of Birth

_____ _____

Relationship Phone number

_____ _____

Print Name Date of Birth

_____ _____

Relationship Phone number

JERSEY SHORE RETINA

Phone: 722-RETINAS
www.jsretina.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *See pages 3 and 4 for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of the responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if we have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint in writing with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you have choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions, such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective

This Notice of Privacy Practices applies to the following organizations.

Jersey Shore Ophthalmology, Retina Consultants, LLC

Please speak with any office staff if you have any questions. You may be asked to speak with the private privacy officer, or a copy of this notification to take home with you.

JSRC | JERSEY SHORE RETINA CONSULTANTS

Consents and Agreements

Authorization to access electronic prescriptions

I hereby authorize JSRC to view my external electronic prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my JSRC medical record.

Authorization for Photograph and Use in Medical Records

I hereby authorize and consent to the taking of photographs or pictures of me by JSRC and its agents or employees, and the use and storage of such photographs for identification purposes and as part of my medical record.

I hereby release JSRC, its staff, agents and employees from all liability related to the making, storage and use of such photographs for identification purposes as part of my medical record.

Video Surveillance

This form provides you with notice that this location is under video surveillance. The images and moving pictures captured herein will be stored on a server. You understand and agree that JSRC is not responsible for breach or theft of such images and/or moving pictures, provided a reasonable effort is made to safeguard it.

Referral to outside providers

You understand and agree that if your insurance company requires you to have a referral for service provided by out of network providers, you are responsible for obtaining this. The physician(s) and provider(s) at JSRC may refer you to providers that are out of network for you. If you desire to be referred only to in-network providers, then you may contact your insurance company for a list of active in-network providers for the relevant service and we would happy to help you select from within that list.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize JSRC through its physicians, employees and/or agents to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiologic, and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my JSRC physician(s), including, but not limited to, collecting and testing of bodily fluid, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I consent to pharmacologic dilation of my eyes by the use of eye drops. I understand that this is a very commonly performed step in ophthalmic examinations, but that there are uncommon but potentially serious side effects. These may include, but are not limited to, angle closure and glaucoma, headache, cardiac arrhythmia (usually temporary if it occurs), and hypotonia. **IF I AM PREGNANT OR THINK I MIGHT BE PREGNANT, I WILL NOTIFY THE STAFF MEMBER OR PHYSICIAN IN PRIVACY BEFORE DILATION DROPS ARE INSTILLED IN MY EYES.** While dilation drops are likely to be generally safe during pregnancy due to the small quantity and route of administration, extra precautions are taken during pregnancy to minimize and/or deny exposure.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the provider(s) in JSRC for the services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments, and benefit services that are out of network, denied and/or not covered by my health insurance plan. I authorize JSRC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross or any other insurance carriers or their authorized agents any information needed for this or a related claim.

FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and services, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our Financial Policy.

It is important for you to understand that health insurance coverage is an agreement between you and your insurance company AND your doctor's bill for services provided is an agreement between you and your doctor.

YOUR Responsibility: Our physician(s) participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you. If you do not have valid insurance information, or we cannot confirm coverage, we will consider you "self pay" and ask for full payment.

All co-payments, co-insurances, deductibles and payments for non-covered services are the patient's responsibility and will be collected by our staff at the time of service.

Referrals: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment of services provided if you fail to supply all required referral forms.

Acuity of need

ALL INSURANCE PLANS, including but not limited to Medicare Replacement Plans, Managed Care and Commercial Carrier Plans: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent you will be responsible for paying the fee for all services at the time of service.

PAYMENT FOR SERVICES PERFORMED

1. Our office accepts Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards and Personal Checks for payment of service. A small service charge may be applicable to all credit card and debit card transactions, and you will be advised of such charge at the time of payment should you use one of these methods.
2. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement.
3. All payments re expected at the time of service. Should your account require action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
4. **A $20 charge may be added to all amount due over 30 days.**

RETURNED CHECK FEE IS $30

CHARGES TO ACCOUNT: We shall retain the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up for an appointment, or fail to reschedule or cancel with the less than 24 hours' notice will be charged a $50.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

MISSED TEST FEE: Patients who do not show up on time for a scheduled office based test, or fail to reschedule or cancel with less than 24 hours' notice will be charge a $150.00 fee. This charge will not be reimbursed by your insurance.

MISSED PROCEDURE FEE: Patients who do not show up on time for a scheduled procedure, or fail to reschedule or cancel with less than 48 hours' notice will be charge a $500.00 fee. This charge will not be reimbursed by your insurance.

RELEASE OF RECORDS: If you require or request a copy of your records for personal use, you must submit a request and pay a copying/printing fee of $1.00 per page, up to State maximum sheet in effect.

Copies of records, including payment history, will be provided at no charge to other healthcare providers pursuant to a valid HIPPA authorization.

RIGHT TO AMMEND: You understand and agree that JSRC may amend the terms of this Financial Policy at any time without prior notification to the patient.