This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Integrated Vision Associates, LLC must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement.
We must follow the privacy practices described in this notice.

We reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.
Without your written authorization, we can use your health information for the following purposes:

1. Treatment: For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

2. Payment: In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.

3. Health Care Operations: We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders or to re-schedule appointments. For example, we may look at your medical record to determine the date, time and type of your next appointment with us, and then send you a reminder or re-scheduling letter or have our automatic telephone appointment reminder system call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact patients who are potential candidates for Laser Refractive Surgery (LASIK), BOTOX, or certain Plastic Treatments or Procedures. Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fund-raising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.

4. As required or permitted by law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

5. For public health activities: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability.
This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

6. For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

7. For activities related to death: We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

8. For organ, eye or tissue donation: We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.

9. For research: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

10. To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

11. For military, national security, or incarceration/law enforcement custody: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

12. For workers' compensation: We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

13. For Integrated Vision Associates, LLC's directory (should one exist): Unless you object, we may use your health information, such as your name, location in our facility, and your general health condition (e.g., "stable," or "unstable") for our directory. It is our duty to give you enough information so you can decide whether or not to object to release of this information for our directory. The information about you contained in our directory will be released to people who ask for you by name. We may allow you to agree or disagree orally regarding the use of your health information for directory purposes.

14. To those involved with your care or payment of your care: If people such as family members, relatives, close personal friends or other persons or organizations are helping care for you or helping you pay your medical bills, we may release important health information about you to those people in person, by letter, by telephone, by facsimile (fax), or by electronic mail (e-mail). The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether or not to object to release of your health information to others involved with your care.

Note: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the Privacy Officer at Integrated Vision Associates, LLC.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Privacy Officer at Integrated Vision Associates, LLC. Specifically, you have the right to:

1. Inspect and copy your health information: With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.
2. Request to correct your health information: If you believe your health information is incorrect, you may ask us to correct the information. You will be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

3. Request restrictions on certain uses and disclosures: You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all

circumstances to your requested restriction. If you receive certain medical devices, (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

4. As applicable, receive confidential communication of health information: You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosures of your health information: In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

6. Obtain a paper copy of this notice: Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.

7. Complain: If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the Privacy Officer of Integrated Vision Associates, LLC, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Privacy Officer of Integrated Vision Associates, LLC. Effective Date: August 17th, 2016

Integrated Vision Associates

ormation and Privacy Practices

Patient Information

Name: _____
First Middle Last

Address: _____

City: _____State:_____ Zip: _____

Tel: _____Cell: _____Email:_____

Birth Date (Mo/Day/Yr.):_____ Age: _____ Sex:_____ Social Security #:_____

Family Physician: _____

Referring Physician: _____ Tel: _____

Emergency Contact (Relationship):_____Tel: _____
Employer: _____ Tel: _____

How Did You Hear About Us?

Friend ☐ Referring Doctor ☐ E-blast ☐ Website ☐ Billboard ☐ Radio ☐ Print ☐ Other ☐

Patient Information and Marketing Materials

I would like to receive emails regarding patient information such as appointments, reminders, etc.

YES ☐ NO ☐

I would like to receive text messages regarding patient information such as appointments, reminders, etc.

YES ☐ NO ☐

Billing Information: Please bring insurance cards to your visit or mail a copy to expedite your registration

If policy holder is other than patient, please complete

Name of insurance:_____ Primary ☐ Secondary ☐

Policy holder name:_____ Policy #:_____

Birth Date (M-D-Y):_____ Age: _____ Social Security #:_____

Work Comp. (Voc. Rehab):_____

Notice of Privacy Practices:

I authorize the following person(s) to have access to my health information

Name / Relationship to Patient:

_____

Name / Relationship to Patient:

_____

By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Integrated Vision Associates, LLC, which outlines how they may use and disclose my protected health information. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Integrated Vision Associates, LLC. I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Integrated Vision Associates, LLC at 864-248-4848. I hereby authorize Integrated Vision Associates, LLC to release my health information for purposes of treatment, payment and healthcare operations as described in Integrated Vision Associates, LLC Notice of Provider Privacy Practices.

Name: _____ Date: _____

Patient / Guardian / Guarantor