

## ATTENTION ALL PATIENTS

Dr. Newman is an ophthalmologist, a medical doctor. We will file your visit under your medical insurance plan. Some insurance plans offer vision benefits. If you have a vision plan under your medical insurance, you must advise our staff prior to being taken back for work up. Once your exam begins, we cannot change to a vision exam. If you have vision benefits, please be aware we will not address medical issues during a vision exam.

We accept several vision insurance plans, VSP, Davis Vision and EyeMed Access. If you are covered under any of these, you must advise our staff prior to workup.

Our aim is to provide excellent eye care to all our patients. Please help us by providing the above information.

IF YOU HAVE VISION  
INSURANCE OR VISION  
BENEFITS WITH YOUR MEDICAL  
PLAN,

**YOU MUST ADVISE  
OUR OFFICE AT THE  
TIME YOU SCHEDULE  
YOUR APPOINTMENT**

ALL APPOINTMENTS ARE SCHEDULED AS  
MEDICAL UNLESS OTHER WISE INSTRUCTED  
BY THE PATIENT AT THE TIME THEY  
SCHEDULE.

ONCE YOUR EXAM BEGINS, IT CANNOT BE  
CHANGED TO VISION.

## FINANCIAL POLICY CENTER FOR SIGHT

Please read this financial/payment policy completely.  
Our staff will be happy to answer any questions you may have.

1. You will be asked to provide your insurance card and picture ID at each encounter. This is not meant to inconvenience you, but to keep your information up to date, as insurance information can change frequently. You will be required to pay for your visit if you do not provide proof of verifiable insurance.
2. It is your responsibility to understand the rules and terms of your insurance. We cannot explain coverage, benefits or guarantee our participation status in your specific plan. You must obtain this information from your insurance carrier, by telephone or on-line, or the human resources representative of your employer prior to your visit.
3. You are responsible for your total charges. As per our insurance contracts, we will file the claim and bill you for any unpaid balances that are due.
4. All co-payments and estimates of unsatisfied deductibles will be collected at the time of service. You may be asked to reschedule your appointment if you have not made prior payment arrangements. Patients may set up payment arrangements with the office manager and will be required to sign a payment agreement. We accept cash, checks, and most credit cards.
5. **Cancellation Policy** states failure to cancel or reschedule an appointment 24 hours prior to your appointment time may result in a **\$35.00** fee. **This fee will be the patient responsibility and will not be submitted to your insurance.**
6. All returned checks are subject to a service charge of \$40.00.
7. Unpaid accounts may be referred to an outside collection agency that will report to the credit bureau and/or resort to legal action.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Center For Sight Cancellation Policy

We value our patients and have reserved your appointment time especially for you. We want our patients to place the same value on our services.

**Appointment cancellations and rescheduling require a 24-hour notice.**

Missed appointments and late cancellations may be subject to a **\$35.00** fee. Although we make every attempt to reach you prior to your appointment, the office cannot be held responsible for appointment reminders. **You are responsible for keeping your appointment.** If you cannot keep your appointment, you may contact our office at any hour by calling:

**770-922-2201**

**If you fail to give 24 hour notice, you will be personally responsible for the charge. It is not covered by your insurance plan. Future appointments will not be scheduled until this fee is paid.**

Continued failure to cancel appointments 24-hours in advance or habitual rescheduling of appointments may result in termination of service.

Please acknowledge below that you have read and understand this policy.

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Signature of Patient or Legal Guardian

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Date



### **Refractions and your eye exam:**

A complete eye exam involves a series of tests designed to evaluate your vision and check for eye diseases. Dr. Newman may use odd-looking instruments, aim bright lights directly at your eyes and request that you look through a seemingly endless array of lenses. Each test during an eye exam evaluates a different aspect of eye health and your vision.

The eye doctor can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). The extent of vision difficulty can be determined. The information obtained from a refraction test helps provide the correct prescription for eyeglasses for each person. It also will determine if you need bifocals.

This test should be done as part of a routine eye test to determine if a person has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments or diseases of the eye.

The test must be used to determine if glasses are needed and to prescribe the glasses.

**Medicare and most insurance companies *DO NOT* cover the cost of refraction. You may be asked to pay for this service on the day of your visit if we know your insurance does not pay for this test. If we file your insurance and it is denied you will receive a bill for this service.**

**The charge for this service is**

**\$45.00**

# HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Center For Sight  
1400 Wellbrook Circle Suite 100  
Conyers, GA 30012  
770-922-2201

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

05/21/09

## **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

**Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

# **ATTENTION:**

Effective April 10, 2013

There will be a \$35.00 fee for copies of medical records to the patient up to 25 pages. After 25 pages a charge of \$1.00/page will be added. Release of records to a physician for the two most recent office visits will be provided at no charge. Complete records to physicians, full fees will apply.

There will be a \$35.00 fee to fill out any other medical forms.

**PLEASE ALLOW 10 DAYS FOR PROCESSING**