Sharing of Personal Information: I authorize Westlake Hills Vision Center's medical staff to discuss my healthcare information (which may include history, diagnosis, test results, treatment and other health information) with the people listed below. This release authorization will remain in effect until terminated in writing by me.

My healthcare information by be released to the following people:
Name _____ Relationship _____ Contact info _____

Name _____ Relationship _____ Contact info _____

____ Do **NOT** release my personal healthcare information to anyone

Privacy: We will do our best to protect the privacy of your medical information. As per Federal Regulations, we have implemented a privacy policy and assigned a privacy officer. **An overview of our Privacy Policy is available for you at our front desk.** If you wish to see the entire policy, lease ask any staff member.

__ I DO __ I DO NOT allow you to leave a detailed message for me at my preferred method(s) of contact

Attestation

I authorize and request my insurance company to directly pay Westlake Hills Vision Center for any health benefits resulting from care I received from Westlake Hills Vision Center. I understand that my insurance company may not cover all services rendered on my behalf and I agree to assume responsibility for any services or materials not covered. I consent to the release to my insurance company of any medical records necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by my insurance company are **DUE IN FULL AT THE TIME OF SERVICE.**

I understand that the insurance that I wish to use for an exam must be presented at the time of the exam and cannot not be changed after.

I understand that failure to provide complete and accurate information may result in denied or delayed insurance claims, an inaccurate diagnosis, or even inappropriate treatment. I certify that the information I have given is accurate and complete.

I acknowledge that I been offered or received a copy of Westlake Hills Vision Center's Notice of Privacy Practices. I also authorize my insurance benefits to be paid directly to my provider, when such arrangements are made in advance. I understand that I am financially responsible for denied claims and non-covered services and/or materials. .

Signature: _____ Date: _____

Susan Elizondo, O.D.
Notice of Privacy Practices

Effective Date: Feb 01, 2019

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Susan Elizondo, O.D. is required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide with this notice of its legal duties and privacy practices with respect to your health information. Susan Elizondo O.D. reserves the right to change our practices and this Notice and to make the new notice effective for all medical information it maintains. Upon request, will provide a revised Notice to you.

Susan Elizondo O.D. May Use or Disclose Your Health Information

Susan Elizondo O.D. protects the privacy of your health information. The law permits Susan Elizondo O.D. to use or disclose your health information for the following purposes:

Treatment, Payment and Regular Health Care Operations – Information obtained by Susan Elizondo O.D. will be used to dispense and provide prescription ophthalmic goods and services to our, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you.

Information will also be provided to you upon your request.

As and When Required by law – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigation, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensations programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.

Personal Communications – We may contact you to provide appointment reminders, annual eye examination cards, and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment of your care.

Disclosure to Our Business Associates – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to their business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for the services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.

Victims of Abuse, Neglect, or Domestic Violence – We may disclose your health information to a government authority, such as social service or protective services agency, if Susan Elizondo O.D. reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communication. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

When Susan Elizondo O.D. May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Susan Elizondo O.D. will not use or disclose your health information without your written authorization. If you do authorize Susan Elizondo O.D. to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information

You have the right to request restriction on certain uses and disclosure of your health information. To make such a request, you must complete the **Restriction of the Use of Patient Information form** and the request will apply to the location providing services. Susan Elizondo O.D. are not required to agree to the restriction that you requested.

You have the right to inspect and copy your health information as long as Susan Elizondo O.D. maintain the health information. Your health information usually will include prescription and billing records. To inspect or copy your health information, you must complete a **Request to Inspect Medical Records form** and submit the request to the location that provided your services. Susan Elizondo O.D. may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

You have the right to request that Susan Elizondo O.D. amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request to Amend Medical Records** to the location providing services. Susan Elizondo O.D. are not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.

You have the right to receive an accounting of disclosure of your health information from Susan Elizondo O.D. for most purposes other than treatment, payment, healthcare operations, information provided to you, and certain government functions. To request an accounting, you must complete a **Request for Accounting of Disclosure** to the address listed below. You must specify the time period but may not be longer than six years. Susan Elizondo O.D. will notify you of the cost involved and you may choose to withdraw or modify your request at the time. You may request communications of your health information by alternative means or at alternative locations. For example, you may request that Susan Elizondo O.D. contact you about medical matter only in writing or at a different residence or post office box. To request confidential communication of your information, you must complete a **Request for Alternative Communication** to the location providing services and will be good for only the location providing services. Your request must state how or when you would lie to be contacted. Susan Elizondo O.D. will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, contact Susan Elizondo O.D. at the location that services were provided, or submit a written request to: Susan Elizondo O.D., 3801 N Capital of Texas Highway, C-100, Austin, TX 78746.

Changes to this Notice of Privacy Practices

Susan Elizondo O.D. reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, Susan Elizondo O.D. are required by law to comply with this Notice. The revised notice will be posted in the office of Susan Elizondo O.D. and will be available upon request.

For More Information or to Report a Problem

If you have questions or would like additional information about the privacy practices of Susan Elizondo O.D., you may contact Susan Elizondo O.D. at the address above. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services.

I have reviewed and/or received the Notice of Privacy Practices for Susan Elizondo, O.D. I authorized the payment of medical benefits to the undersigned physician and authorized the release of medical or other information necessary to process this claim.

Patient's Signature _____ Date_____
(Parent or Guardian if minor)

Contact Lens and Glasses Policy

We give a 90 day window after the initial contact lens fitting in which you are able to have your contacts adjusted at no charge. If you would like your contacts adjusted outside this time due to vision or comfort you will be recharged the initial contact lens fitting fee and the 90 day window will reset. Contact lens prescriptions once finalized are good for 1 year. If your irritation in contacts at a F/U is due to a medical issue it will be charged as an OV.

We give a 90 day window from the date a prescription was issued for adjustments to a glasses prescription. If you feel you have a prescription change outside 90 days but before 6 months from the initial time the prescription was issued we do charge a $50 refraction fee. If the change in vision is due to other issues such as allergies, corneal irritation, or diabetes that needs to be addressed there may be an office visit fee. If you would a like a prescription update 6 months or more after the initial prescription was given a new exam will required.
Please be aware that glasses are custom products. Once an order is placed we do not offer a refund but we can remake the lenses once if there is an adaptation issue.

Signature _____ Date _____

Vision Vs Medical Insurance

Vision Insurance

Vision insurance covers an eye exam if you only have a prescription and want no other health conditions addressed. For instance if you are near-sighted (myopia), far-sighted (hypermetropia), have astigmatism or presbyopia (loss of near vision) and have not been diagnosed with any other conditions or would not like any other conditions addressed the exam would fall under vision insurance. If there is anything else that you would like discussed during the exam such as red eyes, dryness, allergies, or any drug prescription updates this would fall under medical and a separate visit may be needed. It would also fall under medical if you have been previously diagnosed with conditions such as cataracts, diabetes, glaucoma, macular degeneration etc. and would like them addressed.

Medical Insurance

Medical insurance will sometimes cover a routine exam where you have no health conditions but it is dependent on the medical insurance and your individual coverage. If you have ever been diagnosed with health conditions such as diabetes, macular degeneration, glaucoma, choroidal

nevus (a freckle in the back of the eye) and would like them addressed the exam would fall under medical insurance and may be covered under your optometry benefit. If your medical insurance does not cover a routine exam the refraction portion of the exam is not covered. The refraction portion of the exam is the part where we determine your prescription. This part would be out of pocket. This is often the case with Medicare if you do not also have vision insurance. With some insurances if you have both medical and vision we can coordinate benefits so the vision insurance will pay for the refraction and the medical will pay for the exam. However, this is not possible for every insurance. For instance, this is not possible if the vision insurance is Eyemed. I understand that my exam will be filed based on the above guidelines. Those guidelines are dictated by your insurance.

Signature _____ Date: _____

Westlake Hills Vision Center Frame Waiver

We will happily adjust and maintenance a frame not purchased from Westlake Hills Vision Center. Every effort will be made to use the utmost care while handling your frame. However, we cannot be held liable for any damage that may occur when inserting new lenses into or adjusting any frame that is not purchased or currently warrantied through Westlake Hills Vision Center. Adjusting includes any service that requires frame handling such as inserting nose pads or screws. All frames purchased through Westlake Hills Vision Center carry a 1 year warranty. Although rare, if you choose to use a your own frame but have new lenses inserted, should breakage occur when lenses are being inserted at the lab, Westlake Hills Vision Center will not be financially liable but will offer a 30% discount on any other frame a patient wishes to use for lens insertion.

Patient/Guardian Name: _____

Signature: _____ Date:_____