Abba Eye Care Inc.

Corporate Office: 1130 Lake Plaza Dr. Suite 245, Colorado Springs, CO 80906
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our 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).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you 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.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint 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 can tell us your 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: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) 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: 1) Marketing purposes. 2) Sale of your information. 3) 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. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

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: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) 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: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) 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

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) 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. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) 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.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Abba Eye Care Inc. Notice of Privacy Practices.

Patient name_____

Signature_____Date_____

ABBA EYE CARE
The Best in Sight Since 1978

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best and most comprehensive care possible. We encourage you to ask questions. In order to bill your insurance carrier, we need complete and accurate information.

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS	
CITY, STATE		ZIP	BEST CONTACT PHONE NUMBER	
PATIENT DATE OF BIRTH MM/DD/YYYY	PATIENT SSN	SEX ❑ Male ❑ Female	EMAIL ADDRESS	
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

VISION INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
MEDICAL INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
OTHER INSURANCE NAME (if applicable)	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

Authorization to release health information to:

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:
❑ All Records ❑ Eyeglass or Contact Lens Prescription

Patient/Guardian Signature	Date MM/DD/YYYY

Financial Policy Acceptance
I have been given the opportunity to read, understand and ask questions about the Financial Policy located on the back of this form. (Revision Date located at the bottom left corner of the page)

Patient/Guardian Signature	Date MM/DD/YYYY

Financial Policy for Abba Eye Care

We are pleased that you have chosen Abba eye care to provide your care and services. We would like to take a moment to inform you of our payment policies. We accept cash, check and credit card payment on your account.

Eye Examination: Some health insurance carriers will not cover eye examinations for the purpose of obtaining glasses. Most carriers will not cover the refraction fee (strength of the lenses) for determination of appropriate lenses. If you have a vision plan, all or a portion of these charges may be covered. You will be responsible for those charges determined by your insurance as non-covered which is your portion

No Insurance/Non-contracted: If you don't have insurance, we expect you to pay your visit, glasses and/or contacts at the time of service. Non-contracted insurance will be billed if appropriate information is given, however, payment is expected at the time of service. If we are requested to bill insurances at a later date, a billing fee may be added.

Medicare: We are participation with the Medicare program. We will submit your claim/services to Medicare. You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us. Medicare does not cover refraction (strength of the lenses)- this fee will be your responsibility at the time of service. Medicare only covers frames and lenses after cataract surgery. You will be responsible for payment of these items in addition to your co-insurance or deductible for your examination.

Medicaid and Medicaid HMO: We do participate with the Medicaid program and Medicaid HMO. Each visit you must provide us with a copy of your Medicaid card indicating that you are still eligible for Medicaid. Should services be rendered, and you are no longer eligible for Medicaid coverage or have changed to Medicaid HOM without notifying us, you will be responsible for payment based on our normal fee schedule. All co-pays are to be paid on the day of service.

Contracted Insurance (HMO, PPO, EPO, POS): If you have insurance or vision plans that we are contracted with; we will submit your insurance claims for you if you supply us with the appropriate information. This includes a copy of your card, an address to submit claims to, ID number/Social Security Number and a telephone number to allow us to verify coverage. You are still responsible for your co-payment at the time of service, and any amounts not covered by your insurance, including deductibles. If your coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

Assignment of Benefits I hereby assign my insurance benefits to which I am entitled. I authorize and direct my insurance carrier(s) including Medicare, private insurance, and other health/medical plans to issue payment check(s) directly to Abba Eye Care for services rendered to my dependents or me, regardless of my insurance benefits, if any.

I have requested medical services from Abba Eye Care on behalf of my dependents or myself, and I understand that by making the request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

In the event my account becomes delinquent, I will be responsible not only for the charges incurred, but also any costs involved in collection of my account. These include, but are not limited to, interest charges, rebilling fees, court costs, attorney fees, and collection cost. Insurance coverage is a matter between my insurance company and myself**; I am ultimately responsible for the payment of my account.**

COMPREHENSIVE HISTORY FORM

GENERAL HISTORY

DATE:_____/_____/_____

Name: _____ Name you prefer to be called: _____

Date of Birth:_____/_____/_____ Age: _____ Occupation: _____

How you were referred to us? _____ Hobbies: _____

Date of last eye exam:_____/_____/_____ Name of previous eye doctor: _____

How many hours per day do you spend on the computer? _____

OCULAR HISTORY

Please check all appropriate reasons for your visit today:

☐ Blurred Vision (BV)
☐ Headaches (HA/MIG), If yes:
How often?_____
Location:_____
Duration:_____
Onset:_____
Severity:_____
Time of Day:_____
How you get relief:_____

☐ Dry Eye (DE)
☐ Itchy Eyes (IE)
☐ Red Eyes (RE)
☐ Burning/Tearing (BT)
☐ Painful Eyes (PE)

☐ Floaters (FL)
☐ Flashes of Light (FOL)
☐ Sensitivity to Sunlight (PS)
☐ Glare from lights at night (GN)
☐ Double Vision (DV)

☐ Lazy Eye (LZ)
☐ Crossed "Turned" Eye (XE)
☐ Cataracts (CAT)
☐ Glaucoma (GLC)
☐ Macular Degeneration (ARMD)

Do you: Wear Contacts? ☐ Yes ☐ No Are you interested in Contacts? ☐ Yes ☐ No
If yes, what type/brand?_____ Hours worn per day:_____
When did you last wear Contacts?_____ How old are they?_____
Are you interested in Color Contacts? ☐ Yes ☐ No

SOCIAL HISTORY

Do you: Smoke? ☐ Yes ☐ No If yes, how many cigarettes per day?_____
Drink? ☐ Yes ☐ No If yes, how many drinks per day?_____

Are you considering laser refractive surgery?
☐ Yes ☐ No

MEDICAL HISTORY

Date of your last medical exam?_____/_____/_____ Name of Physician: _____

List all of the conditions you have, the **YEAR** it was **FIRST DIAGNOSED**, and **ALL MEDICATIONS** you're taking for each:

☐ Y ☐ N Surgeries/Operations: _____
☐ Y ☐ N Allergies to Medications and other allergies: _____
☐ Y ☐ N Immune System (HIV, Lupus, MS, etc): _____
☐ Y ☐ N Sinus: _____
☐ Y ☐ N Respiratory (Lungs, TB, etc): _____
☐ Y ☐ N Cardiovascular (Chest Pain, High Blood Pressure, etc): _____
☐ Y ☐ N High Cholesterol: _____
☐ Y ☐ N Stomach, Colon: _____
☐ Y ☐ N Neurological (Seizures, Paralysis, etc): _____
☐ Y ☐ N Arthritis, Bones, Joints, Muscles: _____
☐ Y ☐ N Endocrine (Diabetes, Thyroid, etc): A1c_____(___/___/___) BS_____(___/___/___)
☐ Y ☐ N Integumentary (Skin, etc): _____
☐ Y ☐ N Blood (Anemia, Dyscrasias, etc): _____
☐ Y ☐ N Behavioral (Depression, etc): _____
☐ Y ☐ N History of Stroke or Head Injury, Cancer: _____
☐ Y ☐ N Pregnant (How many weeks: _____) or Breast Feeding
Please list any disabilities: _____

Joint Pains	☐ Y ☐ N
Swelling of Joints	☐ Y ☐ N
Chest Pain	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N
Sinus Trouble	☐ Y ☐ N
Ringing of Ears	☐ Y ☐ N
Enlarged Glands	☐ Y ☐ N
Frequent Infections	☐ Y ☐ N
Chronic/Frequent Cough	☐ Y ☐ N
Shortness of Breath	☐ Y ☐ N
Recurrent Stomach Pain	☐ Y ☐ N
Heartburn	☐ Y ☐ N
Changes in Skin	☐ Y ☐ N
Changes in Weight	☐ Y ☐ N
Anxiety	☐ Y ☐ N
Sadness	☐ Y ☐ N

FAMILY HISTORY

Check if anyone in your family has had any of the following: Please specify Maternal (M) or Paternal (P)

☐ Cataracts ☐ Blindness ☐ High Blood Pressure ☐ Arthritis
☐ Retinal Problems ☐ Macular Degeneration ☐ Diabetes ☐ Thyroid
☐ Glaucoma ☐ Lazy Eye ☐ Heart Disease ☐ Neurological Diseases

DILATION

DILATION is a recommended procedure for most patients to help rule out certain eye diseases with the potential for partial or total loss of vision and without dilation they may go undetected. Most people experience an increased sensitivity to light and blurred vision at near, especially reading for 3-4 hrs and sometimes longer.

Being advised of the above I choose to have my eyes dilated. ☐ Yes ☐ No Dr's. Signature: _____
Dr. has reviewed all elements & history.

I have read, agree and answered the above to the best of my knowledge. I have answered correctly and truthfully:

Patient Signature: _____ Date:____/____/____