DEREK S. LONG, O.D.
MAUMELLE EYE CARE
102 Towne Centre Dr. Ste. 1
Maumelle, AR 72113
501.803.3937
CONTACT PERSON: Derek S. Long, O.D.

NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

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.

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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purpose are: asking about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health Care Operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for Health Care Operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

1. when a state or federal law mandates that certain health information be reported for a specific purpose;
2. for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
3. disclosure of governmental authorities about victims of suspected abuse, neglect, or domestic violence;
4. uses and disclosures from health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
5. disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
6. disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
7. disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
8. uses or disclosures for health related research;
9. uses and disclosures to prevent a serious threat to health or safety;
10. uses or disclosures for specialized governmental functions, such as for the protection of the president or high ranking government officials, for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
11. disclosures of de-identified information;
12. disclosures relating to worker's compensation programs;
13. disclosures of a "limited data set" for research, public health, or health care operations;
14. incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
15. disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

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. Unless you tell us otherwise, we will mail you an appointment reminder on a post care, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not at home.

OTHER USES AND DISCLOSURES

We will not make any other uses or discloses of your health information unless you sign a written "Authorization Form". The content of an "Authorization Form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is

your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed Authorization Form, or you can use one of ours.

If we initiate the process and ask you to sign an Authorization Form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

1. ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.
2. ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E Mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost.
3. ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have on 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension.
4. ask us to amend your health information if you think that is incorrect or incomplete. If we agree we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the incorrect information, and others that you specify. If we do not agree, you can write us a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of your position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension.
5. get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing.
6. get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already.

To request information on any of the above listed items send a written request to the office contact person listed at the beginning of this Notice.

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 notice 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 complain to the office contact person at the beginning of this Notice. If you prefer, you can discuss your complain by phone.

FOR MORE INFORMATION

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

Medical History Questionnaire

Patient's Name: _____ Last Eye Exam: ___/___/_____ Today's Date: ___/___/_____

Spouse's Name: _____ Last Medical Exam: ___/___/_____

Address: _____ DOB: ___/___/_____ Age: _____ Sex: M F Race: _____

_____ Home Phone: (_____)_____

Mobile Phone: (_____)_____

Preferred Contact Method: (Please check) ☐Home ☐Cell ☐Text ☐Email Email Address: _____

Patient's Social Security#: _____-_____-_____ Occupation and Employer: _____

Health Insurance: _____ Work Phone: (_____)_____

Vision Insurance: _____

Policy Holder Name: _____ Policy Holder Name:_____

Policy Number: _____ Policy Number: _____

Policy Holder Social Security#: _____-_____-_____DOB: ___/___/____ Policy Holder Social Security #: ___/___/_____ DOB: ___/___/_____

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	Self	Relationship To You
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____				_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ No ☐ Yes

If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe: _____

_____

Do you use tobacco products? ☐ No ☐ Yes

If yes, type I amount I how long: _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, type I amount I how long: _____

Do you use illegal drugs? ☐ No ☐ Yes

If yes, type I amount I how long: _____

Have you ever been exposed to or infected with: ☐ **Gonorrhea** ☐ **Hepatitis** ☐ **HIV** ☐ **Syphilis** ☐ **Herpes Simplex** ☐ **Shingles**

If you answered YES to any of the above or have a condition not listed, please explain & list medications: _____

_____

_____

_____

_____

Maumelle
EYE CARE

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and understood Derek S. Long, O.D.'s Notice of Privacy Practices.

Patient Name (Printed):_____ Date:_____

Signature of Patient or Legal Guardian:_____

INSURANCE SIGNATURE ON FILE:

I certify that the information given to me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor, Derek S. Long, O.D., to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Maumelle Eye Care for any services and materials furnished. I authorize any holder of medical information needed to determine these benefits payable to related services. If I have any other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor, Derek S. Long, O.D., to act as my agent, as above.

Patient Signature: _____ Date:_____

There are certain special procedures that may be advisable for more thorough eye health testing, such as a refraction retinal photography, slit lamp photography, threshold visual field testing, corneal pachymetry, and tonometry, among others. These procedures may or may not be covered by your major medical insurance provider; or if you have an annual deductible, these procedures may be counted towards that amount. In either event, I agree to pay for these special procedures, if they are deemed necessary, and if my major medical insurance provider does not cover it (them) and/or if my deductible has not yet been met.

Patient Signature:_____ Date:_____

Maumelle
EYE CARE

Office Policies

FINANCIAL

1. Payment for all professional services is due on the date of service. This includes co-pays, past due balances, and exam fees. For you convenience, we accept cash, checks, Visa, MasterCard, American Express, Discover, and Care Credit.
2. There are two types of insurance that will help pay for your eye care services and optical products: vision and medical. Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems). Medical insurance must be used for medical eye care. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other.
3. Our office will file our patients' insurance as a courtesy to them. Patients are responsible for all co-payments, deductibles, co-insurances, and all other charges not covered by insurance.
4. A refraction gives you a prescription for glasses. Some insurance plans do not cover a routine refraction. Patients are responsible for the $40 cost if the insurance plan deems the procedure as a non-covered charge.
5. It is your responsibility to provide our office with your current insurance information at the time when your appointment is made and present your card on the date when your services are rendered. If you provide incorrect or expired insurance information, you will assume full financial responsibility for all charges incurred.
6. Maumelle Eye Care will help you receive your maximum benefits when you have provided us with the necessary current insurance information at the time of your examination. On the date of service, our office will help explain insurance benefits to our patients. We hope that each of our patients will leave our office with an understanding of how their benefits were applied to their examination and materials.
7. Maumelle Eye Care will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage, etc.
8. If your insurance company has not paid the balance within 60 days of service, and it is determined that they will not be paying, you will have 30 days to pay the balance. Should the account be referred for collections, you will be responsible for collection fees and expenses.
9. Patients must have a $0.00 balance with Maumelle Eye Care to receive any copies of their personal records; this includes glasses and contact lens prescriptions.
10. Patients not using vision or medical insurance may use our prompt pay option of $105.00 for the cost of the exam. This must be paid on the date of service.
11. New patients are expected to arrive 15 minutes early to fill out paperwork before their exam. Any patient that is 15 minutes late for their appointment will have to reschedule. If you do not notify the office 24 hours in advance, there is a $10 no show fee for each missed appointment.
12. Any bounced personal checks received by Maumelle Eye Care are subject to a fee of $20.00, which is to be paid in addition to the original amount on the check within 90 days.

I have read and understand the above information regarding my financial obligation to Maumelle Eye Care.

Patient Name (Printed):_____ Date:_____

Signature of Patient or Legal Guardian:_____

Maumelle
EYE CARE

EYEWEAR: GLASSES

1. Eyeglasses are custom-made for each patient, so there are no returns or exchanges for purchased eyewear (includes non-prescription sunglasses). If there is a problem with the prescription or craftsmanship of the glasses, they must be returned within **30 days of the dispense date**. During the 30 day period, we can verify your prescription and even remake your lenses free of charge. After the 30 days, a patient with prescription issues will have to see the doctor to receive a new glasses prescription. Patient will be responsible for a $40.00 refraction fee.
2. All prescription frames receive a manufacturer's warranty for one year after the date of purchase against any manufacturer's defects. Manufacturer's defects include: structural design, hinges, welding points, and coloring. Manufacturer's defects DO NOT include: flagrant misuse causing frame damage, scratching or tarnish, pet damage, destruction or damage by vehicle, stepping on or sitting on the frame, bending or twisting the frame, chewing causing teeth marks, use of superglue, or any other damage not considered a manufacturing flaw. Theft or loss of glasses is not covered under warranty. This is a one year manufacturer's warranty that may be redeemed one time in that year period.
3. The technology does not exist to "buff out" or polish lenses to fix scratches or chips. Fortunately, if you choose our polycarbonate lenses you receive a one year scratch warranty (may be redeemed one time in that year), while with our Crizal™ (anti-reflective) lenses you receive a two year scratch warranty (may be redeemed two times in that two year period).
4. During your thirty day satisfaction warranty, if you choose to add features to your lenses, you will be charged only the applicable upgrade fees. If you chose to remove features, we cannot offer refunds but will make a new set of lenses at no charge to you.
5. Due to the customization of eyeglass orders, patients will be charged if an order cancellation occurs. If a cancellation is received before the glasses are delivered from the lab to Maumelle Eye Care, the patient will be responsible for a 30% restocking fee. If glasses have been delivered from the lab to Maumelle Eye Care, the patient is responsible for paying the full cost of the glasses.
6. For a glasses order to be placed, our office requires payment of half of the cost of the glasses. The glasses may be picked up once the second half of the glasses payment is paid.
7. Glasses orders typically take about **7-10 business days** to be completed and returned from our lab. Please be aware that certain insurances require glasses orders to be processed at other lab facilities and those orders are not returned to our office within our 7-10 business day time standard.
8. Maumelle Eye Care is able to replace new lenses into a patient's own frame. Please be advised that used frames can lose their original shape and durability. Putting new lenses in used frames may cause them to break during the process. Our office will not be held responsible for damage or breakage to customer's own frame, new or used, if only prescription lenses are ordered. We will be happy to give a 20% discount on our selected frame collection if damage or breakage occurs.
9. We will adjust frames, replace screws, re-insert lenses, and replace nose pads free of charge when these procedures can be done in our office. Please note that repairing frames may result in different colored screws, or small scratches on or around frame hinges. We reserve the right to refuse adjustment if we conclude that it will cause further damage or breakage to the eyewear.
10. If you take your prescription and have it filled at a location other than Maumelle Eye Care, the prescription guarantee falls under the policy of whom ever made the glasses. Maumelle Eye Care will not be held responsible for errors on prescription glasses we did not fill.
11. All eyeglasses that have been ordered at Maumelle Eye care will be kept in the office for a total of **six months** after the date of notification to the patient. If the patient does not pick up his/her glasses within the six month time policy, the glasses will be returned to the lab and the patient will **NOT** receive a refund for any payment made towards the glasses.

I have read and understand the above information regarding the glasses policies of Maumelle Eye Care.

Patient Name (Printed):_____ Date:_____

Signature of Patient or Legal Guardian:_____

Maumelle
EYE CARE

EYEWEAR: CONTACTS

1. Our office fits the latest technology in contact lenses to provide our patients with the best possible comfort and clarity of vision. All patients must have a comprehensive eye exam before contacts can be fitted. This is to ensure an accurate prescription and sufficient ocular health to support contact lens wear.
2. Contact lens evaluations are a separate billable service from comprehensive eye exams. They are typically not covered by vision or medical insurance. The cost of a contact lens evaluation is based on the type of contact in which the patient is fit. During contact lens evaluations, patients will be taught proper insertion, removal, and cleaning of contact lenses as a part of their contact lens evaluation.
3. **Non-specialty soft contact lens evaluations** range from $60.00-$80.00 for new patients and $40.00-$60.00 for existing patients. This fee includes a diagnostic pair of soft contact lenses and a sample of solution. Additionally, this fee covers all required contact lens related follow-up visits for three months. This fee does not cover the cost of lenses and lenses will be billed separately. Half down payments is required to process any contact lens orders.
4. With regard to non-specialty soft contact lenses, any unopened and unmarked boxes may be returned for a full credit **within six months** if there has been a change to your prescription.
5. **Specialty rigid gas permeable (RGP) lens evaluations** range from $70.00-$90.00 for new patients and $50.00 for existing patients. This evaluation includes the initial measurements taken at the first appointment and the follow up fitting appointment. Patients must pay half towards the cost of the RGP lens before we will place an order. Once we receive the RGP lenses, we will then set up a fitting appointment for the patient. The patient will pay the other half of the RGP cost at the fitting appointment.
6. **Corneal Reshaping Therapy (CRT) evaluations** cost $1200.00 for new patients. This evaluation includes the fit set of lenses and a spare pair. CRT evaluations for existing patients are $90.00.
7. All sales of specialty RGP, CRT and any XR products are final.
8. Most patients are able to wear contact lenses successfully, but a successful fit and wearing experience cannot be guaranteed. If you discontinue contact lens wear, professional fees are not refundable.
9. Only after a contact lens evaluation has been completed (this may include a contact lens follow up appointment determined necessary by the doctor) and paid in full, can the patient receive a copy of their contact lens prescription.
10. Arkansas State Law states contact lens prescriptions expire after one year. If you are to reorder contacts, it must be within one year of the contact lens exam. **No exceptions**.
11. All contact lenses that have been ordered at Maumelle Eye care will be kept in the office for a total of **six months** after the date of notification to the patient. If the patient does not pick up his/her contact lenses within the six month time policy, the contact lenses will be returned to the lab and the patient **WILL NOT RECEIVE A REFUND** for any payment made towards the contact lenses.

I have read and understand the above information regarding the contact lens policies of Maumelle Eye Care.

Patient Name (Printed):_____ Date:_____

Signature of Patient or Legal Guardian:_____