

# Welcome

Dear Patient,

Welcome to Omni Eye Services at the Eye Health Group. Our highest priority is to provide you with the finest quality and most comprehensive specialty eye care available. Our mission is to make your visit pleasant and comfortable.

Please bring a list of your present medications, your insurance card and referral from your primary care physician (your medical doctor not your eye doctor) if your insurance requires it. Please check with your insurance company if a referral or pre-certification is required for your visit, and if needed, please obtain it prior to your visit. Your co-payment will be accepted in the form of cash, check or Visa, Master card or Discover. Patients with no insurance will be required to pay in full at the time services are rendered.

In order to expedite your registration and decrease waiting time, please complete the attached patient information sheet and bring it with you on the day of your appointment. Please arrive 15 minutes prior to your appointment time to allow processing of your information. Your examination here will be a comprehensive specialty examination.

If you have to cancel or reschedule your appointment, kindly give the office at least 24 hour notice.

We look forward to serving your specialty and surgical eye care needs.

Sincerely,

Omni Patient Support Staff



OMNI EYE SERVICES

Effective date of notice: April 14, 2003

## **NOTICE OF PRIVACY PRACTICES**

Omni Eye Specialists, P.A.  
485 Route # 1 South  
Iselin, NJ 08830  
(732) 750-0400  
(732) 750-1507

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**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.**

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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 medications, or eye medications and faxing them to be filled; 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 purposes are: asking you 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

### **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:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- 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;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for 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;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- 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;
- 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;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government 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;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- 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 card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

#### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures 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's 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 named at the beginning of this Notice.

#### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

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

- 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. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- 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 address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- 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

sixty 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 one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it 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 wrong information, and others that you specify. If we do not agree, you can write 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 position and/or our 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. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- 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. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- 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. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown 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, have copies available in our office, and post it on our Web site.

#### **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.

# Payment Policy

## **Patients with insurance coverage that Omni Eye Services participates:**

Omni Eye Services participates with most insurance companies, but each plan varies by employer and insured. Please know your plan. Co-payments are due and payable at the time of your office visit. Deductible and/ or other balances that are your responsibility will be billed to you once these amounts are determined. If you are a member of an HMO, you are required by your plan to obtain a referral prior to your specialty examination here. *If your plan requires a referral and you have not obtained one, your examination may need to be rescheduled.*

## **Patients who have insurance that we do not participate with:**

As a courtesy, we will bill your insurance for the services rendered. If we do not obtain a payment from your insurance company within 30 days, you will be responsible for immediate payment. Since we do not participate with your insurance, we will not contact your insurance if your claim is not paid.

## **Patients who are not covered by insurance:**

We require payment at the time services are rendered. Please contact the physician and/ or the office manager to discuss a payment plan.

***All unpaid patient balances will be charged 1.5% interest per month beginning 90 days from the date the balance becomes your responsibility.***

I authorize the release of information to determine liability for payment and or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charged all costs including attorney fees incurred with collection of the amount due.

I authorize the release of any medical information necessary to process claims and the release of payment to Omni Eye Services or the physician rendering services.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Insured's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Patient Information

DEMOGRAPHICS

NAME LAST FIRST MI			TODAY'S DATE		
STREET ADDRESS			SOCIAL SECURITY #		
CITY			SPECIAL NEEDS: <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> TRANSLATOR <input type="checkbox"/> WHEELCHAIR		
STATE	ZIP CODE	BIRTH DATE	AGE	SEX <input type="checkbox"/> F <input type="checkbox"/> M	
HOME PHONE ( )		WORK/ MOBILE PHONE ( )		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED	
EMPLOYER NAME/ADDRESS			POSITION/DEPARTMENT		
SPOUSE			WORK PHONE/ MOBILE PHONE ( )		
EMERGENCY CONTACT			PHONE	E-MAIL ADDRESS	

REFERRAL

PLEASE FILL OUT THIS AREA TO LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE					
NAME OF OPTOMETRIST		PHONE ( )	<input type="checkbox"/> PATIENT: NAME _____ <input type="checkbox"/> OTHER PHYSICIAN _____ <input type="checkbox"/> OTHER (INSURANCE DIRECTORY) _____		
LOCATION					
STREET ADDRESS		CITY	STATE	ZIP CODE	
PRIMARY CARE MEDICAL DOCTOR			PHONE ( )		
STREET ADDRESS		CITY	STATE	ZIP CODE	

BILLING

Guarantor (Person Financially Responsible)					
NAME			RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
STREET ADDRESS			PHONE ( )		
CITY			STATE	ZIP CODE	
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S DOB	
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S B/D	
<input type="checkbox"/> WORKERS COMPENSATION					(over)

### **Agreement of Responsibility**

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: \_\_\_\_\_

### **Consent to Treat**

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: \_\_\_\_\_

### **Acknowledgement of Receipt of Privacy Practices**

I acknowledge that I have received a copy of Omni Eye Specialist's P.A. Notice of Privacy Practices.

Initial: \_\_\_\_\_

### **Release of Information/Assignment of Benefits**

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_