THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In 1996, the federal government set forth new guidelines to protect patients' right to privacy. It is important to us, that you understand your rights according to the Health Insurance Portability and Accountability Act (HIPAA). The responsibility of Schneider Eye & Wellness Center is to guard your privacy. It is our duty to maintain the privacy of your Protected Health Information (PHI).

PHI may be used to carry out treatment, payment or healthcare operations in our practice. You have the right to review this notice prior to signing it and not to sign it. If unsigned, you understand this office may choose not to render treatment. Our practice has the right to change privacy practices and the terms of the notice may change and be revised. Your health information may be used to help treat your disease or problem and it may be disseminated to other health care providers in your best interest to help provide you with excellent health care. PHI may also be used in communicating with other doctors who are taking care of you, insurance companies for payment and for our internal operations. Schneider Eye & Wellness Center will also send post-card reminders for appointment dates, may contact you by phone, may leave voice messages and send out emails. By your signature below, you authorize us to use and disclose information about you to help in your treatment. All other uses and disclosures will be made only with your approval.

Our patients have the right to request restrictions on uses and disclosure of PHI for the purpose of treatment, payment and healthcare operation purposes. Should our patients choose to revoke this consent, it must be given in writing to the practice. You may also revoke this authorization in writing to our Security Officer

You have the right to see your own designated record set and may make such a request in writing to our office. You have the right to file complaints against our office if you feel your privacy has been violated. Please report any such violations to our Security Officer, Janice Fontaine at 904-247-5575. You also have the right to report any violations to the Secretary of the Department of Health and Human Services. This notice is effective January 17, 2003.

I, _____, have read and understand this Notice of Privacy Standards for Schneider Eye & Wellness Center. I agree to its terms.

Signature: _____ Date: _____

Please specifically list any other family members or close friends with whom we may share your PHI. Understand that we will not share any information with any person, under any circumstances whose name does not appear on this sheet.

_____

_____

Referred by: _____

Full Legal Name: _____

Preferred Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State**: _____ **Zip code**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email Address: _____

Emergency Contact: _____ **Phone Number:** _____

Primary Care Physician: _____

Race: ___African American/Black ___ American Indian or Alaska Native ___ Asian

___ Hispanic ___ Native Hawaiian/other Pacific Islander ___ White

Ethnicity: ___ Not Hispanic or Latino ___Hispanic or Latino

Language: ___ English ___ Spanish ___ French ___ Dutch ___ Japanese

___Other: _____

Primary Insurance: _____ **Member Number**: _____

Secondary Insurance: _____ **Member Number**: _____

If you have TRICARE please provide the sponsor's social security number as we will need this to bill your insurance.

I authorize the release of any medical information necessary to process this claim. I also request the payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described. I authorize payment of the Medigap coverage to be made on my behalf to Timothy L. Schneider, MD for any services. **I understand that if I do not follow my insurance company's guidelines, I will be responsible for payment. I understand that if for any reason my insurance does not pay for services rendered, I will be held personally responsible for payment in full. I have read and understand all statements contained in this form and my signature below authorizes treatment.**

Signature:_____ Date: _____

Printed: _____

FINANCIAL POLICY

Welcome to our practice. We are pleased to have you as a patient. We would like you to know about our office policy on Billing. The more you know, the more we can be of service to you. If you have any questions, please feel free to speak with anyone in our Billing Department at any time.

Due to the increased cost of providing medical care, we ask that you pay your co-payment, deductible, or co-insurance as you check-out of our office on the same day the services are provided. We understand that situations occur when you may not be able to pay the entire portion. In this case we ask that you speak with our Billing Department prior to your office visit.

Patients on HMOs
Our staff will try to make sure that every patient on an HMO plan has a referral for their visit; however it is the PATIENT'S responsibility. Patients that are seen in our office with an HMO policy are required to bring a referral with them at every visit. Please feel free to call our office before your appointment to make sure we have a referral on file. Failure to bring a referral will result in insurance non-payment, therefore you will be responsible for all charges on that visit.

If we suspect that your insurance company may not cover a service we will ask that you sign a form in advance acknowledging that you have been advised and accept financial responsibility. In addition, we ask that cosmetic surgery, refractive surgery such as LASIK, and elective procedures be paid prior to services being performed.

Our office will bill all covered services to a Primary and Secondary Insurance. We do not bill to more than two insurance carriers. We will give insurance carriers a maximum of 60 days to pay the claim. Failure for them to process the claims in a timely manner will result in it being turned over to the patient's responsibility. We encourage you, the patient, to be involved and make sure your insurance is paying in a timely manner. Returned check charges are $25.00.

After 120 days if a patient-responsibility balance is still on the account without payment arrangements, it will be forwarded to our collection agency. The patient will be responsible for any collection charges that accrue. Continued access to our practice will be terminated if billing policies are ignored.

If financial obligations arise, please contact our Billing Department immediately. Monthly payment plans can be arranged.

I transfer all rights and benefits contained in the policy to Schneider Eye Center, including the right to act as the authorized representative during an appeal and the right to file suit: including the right to obtain disclosure of the summary, plan description, or policy.

I have read and understand the above policy.

Signature of Patient/Guardian Date

Refraction Policy

Welcome to Schneider Eye Center. We are happy to have you as a patient. Performing a refraction is an integral part of your examination with Dr. Schneider. While Medicare and some major insurance carriers do not cover this test, it is often a necessary part of the examination to determine your visual acuity.

Frequently Asked Questions About Refractions (FAQ)

1) **What is Refraction, and why do you charge for it?**
   Often a refraction is used to determine your need for glasses, but it is also used to detect vision loss. Vision loss can be slow and progressive and sometimes the patient may not notice these changes. These changes are detected by refracting the eye and can uncover the cause of the problem. This test is integral to determining a patient's eye health.

2) **Why is this charge separate from the exam?**
   Medicare has determined that a refraction is *not* a medical service and therefore not a covered service. Medicare does acknowledge that this is separate to the rest of the eye exam and therefore there is a separate fee for this service. Most insurance companies have followed Medicare's lead and do not cover the refraction, because they consider the test to be "vision care" and unrelated to the office visit. The problem is that occasionally this is the only way to detect some types of vision loss.

3) **Does Dr. Schneider have to charge for the refraction?**
   The answer is yes, especially for Medicare patients. The Office of the Inspector General has determined that *NOT* charging for a provided service is an "inducement" to the patient and therefore illegal. The federal government insists that if a test is performed, it must be charged for. The government does this because they are worried that some physicians may try to lure patients in to their offices by offering them an incentive such as a reduced fee, and want it to be fair to all doctors and patients who accept Medicare. We are obliged by the government to charge for all of our services.

Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plans' benefits when your healthcare insurance company receives and processes the claim.

ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of the refraction and agree to pay for the refraction at the time of service. Any co-payments due are separate from and not included in the $45 fee for the refraction.

_____ _____

Patient's Signature/ Legal Guardian *Date*

Patient's Name: _____ Date: _____

Current/Past Medical History:

(Circle all that apply to your health history)

Good General Health	Thyroid Disease
Diabetes	Stroke
Hypertension	Heart Disease
High Cholesterol	Heart Attack
Sinusitis	Anemia
Ear Infection	Epilepsy
Intestinal Disease	HIV/AIDS
Multiple Sclerosis	Asthma/Emphysema
Arthritis	Anxiety
Lupus	Sjogren's

Cancer If yes, type of cancer: _____

Other Explain: _____

Ocular History:

Glaucoma	Cataracts
ARMD (Macular Degeneration)	Strabismus
Blindness	Amblyopia

Other: _____

Current Medications and Dosages:

1._____	5._____
2._____	6._____
3._____	7._____
4._____	8._____

Pharmacy: _____ Zip Code of Pharmacy:_____

Allergies: Yes (please list below) No

_____

_____

_____

_____

*****PLEASE TURN OVER AND COMPLETE BACK SIDE OF THIS FORM*****

List Past Surgeries & Dates: (In the last 10 years)

1._____
2._____
3._____

Family Medical History:

(Circle all that apply to your Mother, Father, Sibling or Grandparents)

Stroke	Cancer
Diabetes	Arthritis
Hypertension	Kidney Disease
Heart Disease	Lupus
Thyroid Disease	Other: _____

Family Ocular History:

Glaucoma	Cataracts
ARMD (Macular Degeneration)	Strabismus
Blindness	Amblyopia
Other: _____	

Social History:

Do you drive?	Yes	No
Do you have night vision problems?	Yes	No
Have you worn contact lenses?	Yes	No
Do you currently wear contact lenses?	Yes	No
Do you wear glasses?	Yes	No
Do you use alcohol?	Yes	No
Do you use tobacco?	Yes	No

Are you Married, Divorced, Widowed or Single? _____

Occupation: _____
Employer: _____