

Welcome to our Office

Dr. Jason Cook and the staff of Dawson's Vision Center want to help you meet all your eye care needs. We are committed to giving you prompt courteous service and want you to be completely satisfied with your experience here. We welcome your questions and your comments. If you need any help, just ask!

Patient Information: (Please fill out both sides of this form)

Mr. _____ Mrs. _____ Ms. _____ Dr. _____ Rev. _____ Other/Rank _____
First Name: _____ Last Name: _____ MI: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Ph:() _____ Work Ph:() _____ Ext: _____
Cell Ph:() _____ Birth date: ___/___/___ Social Security #: _____ - _____ - _____
Drivers License Number: _____ Driver Lic. State: _____
Email Address: _____

Responsible Party (fill out only if information is different from patient)

Mr. _____ Mrs. _____ Ms. _____ Dr. _____ Rev. _____ Other/Rank _____
First Name: _____ Last Name: _____ MI: _____
City: _____ State: _____ Zip Code: _____
Home Ph:() _____ Work Ph:() _____ Cell Ph:() _____
Relationship to Patient: _____
SS #: _____ - _____ - _____ Driver Lic. #: _____ Driver Lic. State: _____

Insurance Information

Insurance Company: _____
Policy Holders Name: _____ Date of Birth: _____
Contract or ID #: _____ Group #: _____

Other Helpful Information

Occupation: _____ Employer/School Attended: _____
Main Hobby/Activities: _____
Last Eye Exam: Year _____ Doctor (if known) _____
Current Physician/Pediatrician: _____ City: _____ St: _____
Who referred you to our office? _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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 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 must carry out 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
 - was not created by us, unless the person that created the information is no longer available to make the amendment,
 - is not part of the health information kept by or for us,
 - is not part of the information you would be permitted to inspect or copy, or
 - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

NOTICE OF PRIVACY PRACTICES

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Larry Dawson

Rick Dawson

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: January 01, 2014

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dawson's Vision Center & Jason W. Cook O.D., Notice of Privacy Practices.

Date: _____ Patient name: _____

Signature: _____

Dawson's

VISION CENTER

600 LEGHTON AVENUE
ANNISTON, ALABAMA 36207
256-238-8718 800-588-8718

RELEASE OF RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____

By signing below, you hereby authorize Dawson's Vision Center to disclose information about yourself that is protected under Federal Law. Release of such information may be given to consulting physicians and/or facilities and also may be given to your insurance company. You have the right to not sign this authorization. You have the right to revoke this authorization after it is signed which will prevent future release of information.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____

RELEASE OF MEDICAL INFORMATION

I hereby give authorization for Dawson's Vision Center to call and leave medical information regarding myself and/or child. This information may include but will not be limited to appointments with Dawson's Vision Center or other facilities, results of blood work, results of x-rays or any other information deemed necessary by our office. You or the person we contacting must be able to provide your birth date for verification.

Please check all that apply:

- _____ Notify myself ONLY
- _____ Spouse (please list name) _____
- _____ Answering machine/voice mail
- _____ Mail
- _____ Other (please specify) _____

SIGNATURE: _____ DATE: _____

Dawson's Vision Center
Dr. Jason W. Cook, OD
600 Leighton Avenue
Anniston, Alabama 36207
256-238-8718

INSURANCE AUTHORIZATION

_____ I understand any co-payments required by my insurance is my responsibility and is due at the time of the office visit.

_____ I agree to notify the office of any changes of address, telephone number, or insurance carrier promptly. If I fail to do so, I will be responsible for the charges.

_____ I understand that if my insurance fails to pay for any medical care or materials for any reason, the bill will be my responsibility.

_____ I agree to pay any balances not covered by my insurance. (Example: Procedures not covered, deductibles, refractions, co-pays, etc.)

_____ I accept the fee charged as a lawful debt and promise to pay said fee as outlined, including the cost of collection, attorney fees, and court cost if such should be necessary; waiving now and forever the right to claim exception under the constitution and laws of the State of Alabama, or any other state.

_____ I understand that my insurance is filed as a courtesy to me, and if any problems arise as a result of my insurance, it will be my responsibility to clear my account.

_____ I understand that if for any reason my insurance company pays directly to me for services rendered at that time by Dr. Cook, or for materials purchased from Dawson's Vision Center (and filed by this office), I will be responsible for IMMEDIATELY endorsing the payment to Dr. Cook or Dawson's Vision Center.

THIS GIVES DR. COOK AND DAWSON'S VISION CENTER THE AUTHORIZATION TO FILE AND RECEIVE ANY DIRECT PAYMENT FROM MY INSURANCE COMPANY FOR ALL MEDICAL CARE OR MATERIALS PROVIDED TO ME AT THEIR OFFICE.

NAME: _____ TELEPHONE NO: _____

ADDRESS: _____

SIGNATURE _____ DATE: _____

Dawson's

VISION CENTER

600 LEGHTON AVENUE
ANNISTON, ALABAMA 36207
256-238-8718 800-588-8718

FORM REQUEST FOR LIMITATIONS AND RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **PATIENT SS#:** _____

PATIENT DATE OF BIRTH: _____

PATIENT ADDRESS: _____

Please check the type of patient information below that you wish to be restricted. Please check all that apply.

_____ Date of Service

_____ Patient History

_____ Office Address

_____ Visit Notes

_____ Office Phone Number

_____ Hospital Notes

_____ Occupation

_____ Spouse's Name

_____ Name of Employer

_____ Spouse's Office Phone Number

_____ Prescription Information

Please list below the type of restrictions you would like to make on the patient's PHI.

SIGNATURE: _____ **DATE:** _____