Kozol Vision Center

20 Roche Bros Way Suite 7
North Easton, MA 02356
Phone: 508-238-5200 Fax 508-238-5146

Name of Patient:_____
Last ***First*** ***Middle Initial***

Social Security #: (if applicable)_____ **Home Telephone # :** _____

Email Address:_____ **Cell Phone:**_____

Address:_____**City/State/Zip:**_____

Date of Birth:_____ **Gender: ___M ___F Marital Status:**_____

Demographics

Various studies have demonstrated significant disease variations among different ethnic and racial groups. Your answers will assist us in recognizing these differences that might impact the delivery of your health care. Your provision of this information is voluntary and if provided, confidential.

Which of the following best describes your race/ethnicity?
Please select one:

- Caucasian
- American Indian or Alaska Native
- Asian
- Black or African American
- Cape Verdean
- Caribbean
- Hispanic
- Indian/Pakistani
- Native Hawaiian/Pacific Islands
- Patient Declined Disclosure

Preferred Language:

- English
- Spanish
- Portuguese

Describe your communication preference: Phone E-Mail Other

Emergency Contact:_____**Relationship:**_____**Phone#:**_____

Insurance Information: Medical and/or Vision : Circle Type of Insurance(s) that apply

Name of Policy Holder:_____**Relationship:**_____**DOB:**_____

Policy Holder Phone #_____ **Policy Holder Address:**_____

Employer Information: Name/Address:_____

Employer Phone Number: _____

Is today's visit related to Motor Vehicle or Personal Injury: ___Y ___N

How did you learn of Kozol Vision Center: _____

Primary Care Physician: _____ **Location:**_____

Patient Signature_____**Date:**_____

Medical Information and Payment Authorization

I request that payment of authorized medical benefits be made on my behalf to Kozol Vision Center, Inc. For services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any other insurer, any information needed to determine these benefits payable for related services. A copy or system generated printout of this release will be as valid as the original form.

Although I have indicated that I am covered by the above health insurers(s), I acknowledge and *agree* that I am personally responsible for *any* co-payments and/or deductibles associated with the services I receive. If for any reason it is determined that my insurance is not obligated to pay for said services or that I am in fact not covered by the insurance identified above all charges associated with the services I receive will be my responsibility.

I am responsible for presenting my insurance card to Kozol Vision Center. If my insurance changes to a new plan, I am responsible for notifying Kozol Vision Center of the changes at the time of my visit. Without an insurance card, I understand I will be personally responsible for the payment in full for services received and/or products purchased.

I understand that my eye exam, contact lens fitting or refitting, contact lens teaching, prescription eyeglasses and/or contact lenses may not be a covered benefit of my health insurance plan. I agree to be responsible for payment of services received and/por products purchased if these benefits are not covered by insurance plan.

I understand that it is my responsibility to call my primary care physician to request a referral authorization. If the reason for my appointment requires one, I agree to call my primary care physician with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if a referral is not granted by my primary care physician.

Signature of Patient / guardian: _____ Date:_____

KOZOL VISION CENTER

NOTICE OF PRIVACY RIGHTS & PRACTICES

(Effective April 14, 2003)

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.

As of April 14th, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and currently under Massachusetts law to maintain the privacy of your health information, and to provide *you* with this Notice of Privacy Rights & Practices.

This document explains in detail how *we* use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14th, 2003.

Examples of how we can use and disclose your information without your authorization include:

- Treatment — we keep a record of each visit. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses and other health care and clinical staff providers to offer high quality care to meet your needs.

- Payment — we maintain a record of and may use and disclose information related to, services and supplies you receive at each visit, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payers about an upcoming treatment or service, which requires their prior approval and authorization.

- Health Care Operations - we use and disclose your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes.

Your information may be shared amongst: Other Health organizations, other health care providers, third party payers, and our Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:

I. There are additional times when we are permitted or required to use and/or disclose medical information without your permission. These circumstances are listed below:

- In emergency treatment situations • If required by law
- To assist incommunicative patients • For law enforcement
- So protect victims of abuse, neglect or domestic violence • For public health activities such as tracking diseases
- For organ donations • For health oversight activities such as fraud investigations
- To Workers' Compensation if you are injured at work • For certain judicial or administrative proceedings
- To coroners, medical examiners and funeral directors • For government functions such as national security & intelligence
- To a correctional institution if you are an inmate • To avert serious threat to public health or safety

II. We may also use your information without your permission to:

- Recommend treatment alternatives
- Tell you about health benefits and/or services
- Send or call you with appointment reminders
- To communicate with those involved in your care

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer, except to the extent that we have already taken action in reliance on your authorization.

III. Please know that federal and state law requires special privacy protections for certain highly confidential information about you, including but not limited to:

- Psychotherapy notes
- Mental health and developmental disabilities services
- Alcohol and drug abuse prevention, treatment and referral
- HIV/AIDS testing, diagnosis or treatment
- Venereal disease(s)
- Genetic testing
- Child abuse and neglect
- Domestic abuse of an adult with a disability
- Sexual assault.

In order for-us to disclose your highly confidential information for a purpose other than those permitted by law, we must obtain your written authorization.

Your Rights under HIPAA, you have the right to request in writing:

- Restrictions on how we use or disclose your medical information.
- Confidential communications to an alternate phone or address other than your home.
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply).
- An amendment to your medical information if you feel you or your health care provider needs to make additions or corrections.
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care, operations, or made pursuant to an authorization.
- A paper copy of this notice even if you have received it electronically.
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

Our Responsibilities: We are required by law to maintain the privacy of your medical information, to provide you with this written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our offices, and will be available from your direct treatment provider.

For More Information: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address or phone number below. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy officer will provide you with the correct address of the Director. We will not retaliate against you if you file a complaint with the Director on us.

Kozol Vision Center and its employees are committed to protecting your patient privacy.

Signed: _____

Date:_____

Printed Name:

_____