Bay Eye Medical Group
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION.

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We maintain and share health and financial related records about you in both paper and electronic form. We use this information and disclose it to others for the following purposes:

Treatment. We use your health information to provide health care to you and to coordinate your health care with other providers, and we disclose it to other health care providers electronically to enable them to provide health care services to you. For example, if we refer you to a specialist physician we send all or a part of your health record to the specialist to assist him or her in evaluating and treating you. If your provider is a Participant of a Health Information Exchange your records will visible to other providers that are Participants in the Exchange.

Payment. We use and disclose your health information to obtain payment for health care services we provide to you, including determining your eligibility for benefits. For example, we may send a claim to your insurer that contains information about the services we provided to you, or we may send a bill to a family member who is responsible for paying for your care.

Health care operations. We use and disclose your health information as necessary to enable us to operate our medical practice. For example, we use our patients' claims information for our internal financial accounting activities, and we review health records to ensure quality.

We also disclose health information to our Business Associates who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures for payment or operational purposes. For example, companies that provide or maintain our computer systems may have access to computerized health information in the course of providing services to us.

Contacting you. We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care. Unless you object, we may disclose medical information to a friend or family member who is involved in your care, to the extent we judge necessary for their participation.

Other Disclosures. We may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Here are the general kinds of disclosures we may be required or allowed to make without your authorization:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or to other persons in connection with public health activities
- We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- Disclosures to agencies responsible for overseeing the health care system, for audits, inspections or investigations
- Disclosures for judicial and administrative proceedings, such as lawsuits
- Disclosures to law enforcement agencies
- Disclosures to coroners and medical examiners
- Disclosures to organ procurement agencies, if you are an organ donor or a possible donor
- Disclosures to researchers conducting research under the auspices of an Institutional Review Board or privacy board
- Disclosures to avert a serious threat to health or safety

The foregoing is a general statement of your rights. They are subject to all limitations permitted or required by law.

How do I exercise these rights? You can exercise any of your rights by sending a written request to our Privacy Official at the address below. We encourage you to call our office and speak to us if you have any questions or concerns. Susan Blackwell, Bay Eye Medical Group, 1665 Dominican Way, Santa Cruz, CA 95065, 931-475-7012.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR BAY EYE MEDICAL GROUP

SIGNATURE

Date: _____ Time: _____ a.m./p.m.

Printed Name: _____

Signature: _____
(Patient/ Representative/ Spouse/ Financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Patient Profile

Bay Eye Medical Inc.

Patient Information

Name: _____ Sex: ☐Male ☐Female

Address: _____ Date of Birth: _____

City, State, Zip: _____ Security No.: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Phone 1: _____ ☐Home ☐Work ☐Cell

Phone 2: _____ ☐Home ☐Work ☐Cell Referring Physician: _____

Email: _____ Primary Physician: _____

Patient Employment:

☐Employed ☐Retired ☐Unemployed ☐Other_____

Phone: _____

Employer: _____

Emergency Contact person:

Name: _____

Phone: _____

Relationship: _____

Patient Guarantor: ☐Same as Patient ☐Other

Name: _____ Employer: _____

Address: _____ Employer Phone: _____

City, State, Zip: _____

Date of Birth: _____ Social Security No: _____

Primary Insurance: ☐Same as Patient ☐Same as Guarantor ☐Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security Number: _____

Company: _____ Policy Group: _____

Vision Insurance Plan: _____ Date of Birth: _____

Secondary Insurance: ☐Same as Patient ☐Same as Guarantor ☐Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone: _____ Social Security Number: _____

Company: _____ Policy Group: _____

Vision Insurance Plan: _____ Date of Birth: _____

Signature: _____ Date: _____

CONFIDENTIAL HEALTH HISTORY
REVIEW OF SYSTEMS

Patient Name: _____ **Name of Primary Care Doctor:** _____

Health History			
Do you have a disease of any of the following? (Please describe briefly)		Do you have a disease of any of the following? (Please describe briefly)	
Nose, ears, mouth, throat	Yes/No	Anemia	Yes/No
Sinus congestion/ hay fever	Yes/No	Lupus	Yes/No
Lungs, asthma, breathing probs.	Yes/No	Sjogren's Syndrome	Yes/No
Heart	Yes/No	Neurological	Yes/No
High blood pressure	Yes/No	Headache	Yes/No
Cancer	Yes/No	Migraine	Yes/No
Hormones	Yes/No	Stroke *Date:* _____	Yes/No
Diabetes	Yes/No	Kidney/ bladder	Yes/No
Average blood sugar? _____ Years? _____		Stomach/intestine	Yes/No
Thyroid	Yes/No	Hepatitis	Yes/No
Skin	Yes/No	HIV Positive	Yes/No
Arthritis	Yes/No	Major Surgeries?	Yes/No
Muscles/joints	Yes/No		
Blood	Yes/No	Other medical problems?	Yes/No
High Cholesterol	Yes/No		

Family History

		Relation?
Blindness	Yes/No	_____
Glaucoma	Yes/No	_____
Retinal Detachment	Yes/No	_____
Migraines	Yes/No	_____
Diabetes	Yes/No	_____

Social History

Do you drive? Yes/No
Drink alcohol? Yes/No
Smoke? Yes/No
Occupation _____
Hobbies: _____
How many hours per day do you use a computer? _____

Eye History:

Do you wear contact lenses? Yes/No
If so, what type: _____
Are you interested in laser vision correction?
Have you had prior eye surgery, disease, or injury?
Describe: _____

List all Medication Allergies:

_____
_____
_____

Please list all current medications (or attach a list of them):

_____
_____
_____
_____

Signature: _____ Date: _____

BAY EYE MEDICAL GROUP, INC.

Rex C. Hsei, M.D.
Clement J. Cheng, M.D.
Eye Physicians and Surgeons

LIFETIME AUTHORIZATION OF INSURANCE BENEFITS AND BILLING INFORMATION FOR ALL PATIENTS

Welcome to Bay Eye Medical Group Inc. Because the insurance companies change their carriers' plans and benefits frequently, it is difficult for us to verify that your insurance carrier is one that we are contracted with at the time of your visit. We do attempt to confirm your insurance coverage, but it is not always possible to ascertain this information accurately at the time of your visit. You are encouraged to verify your benefits and whether Bay Eye Medical Group and our doctors are contracted providers prior to your visit. Please be aware that we bill your insurance as a service to you. It is your responsibility to be up to date on your insurance policy and requirements, covered physicians, covered services, deductibles and copayment amounts. Regardless, you will be seen by our doctors as we do not want to withhold services inappropriately. When you check in at the front desk, we will ask to make a copy of your insurance card for your records. Making a copy of your insurance card does not confirm that you have coverage with us.

By signing below, I request that payment of insurance benefits be made on my behalf to Bay Eye Medical Group for

Any services furnished by their physicians / suppliers. I understand that my signature requests that payment be made and authorizes the release of any medical information necessary to ensure payment. This also includes release of **RX to other doctors or optical shops.**

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits on my behalf to Bay Eye Medical Group for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payment for related services. I further understand that Bay Eye Medical has agreed to accept the allowed charge determined by Medicare as full charge. Medicare pays 80% of that charge and I understand that I am responsible for the balance of the charge, deductibles, co-insurance and non-covered services. Co-insurance and deductibles are determined by the carrier. I understand that Medicare excludes all refractive services from their coverage. I agree to be personally and fully responsible for the refractive portion of my exam. If other health insurance coverage is indicated (secondary insurance) my signature authorizes releasing of the information to that insurer or agency.

HMO / PRIOR AUTHORIZATION PATIENTS:

I understand that I am ultimately responsible for authorizations for care / treatment to be provided by Bay Eye Medical Group. If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including co-payments and deductibles.

It is your responsibility to know whether Bay Eye Medical Group is a provider for your insurance company. If we provide services to you and we ARE NOT a contracted provider, your insurance company will notify us that you are liable for either all or a large part of your bill.

PRIVATE PAY PATIENTS

Payment for services rendered is expected at the time of service. We offer a 10% discount for your cooperation and prompt payment on medical services (excluding Laser Vision Correction, medications or materials) if at any time in the future, you become insured with medical or vision coverage, please let our staff know and we will be more than happy to bill for you.We are committed to providing quality service. With the changes in the health care arena, this can be a time consuming process. Thank you in advance for your cooperation and patience.

I have read the above information. I understand that all charges for services rendered are ultimately my responsibility. Should Bay Eye Medical Group, Inc. Not be a contracted provider, or if the services rendered are not a covered benefit under my plan, I am responsible for all charges related to the services provided me and will pay in full for such charges.

_____ _____

PATIENT SIGNATURE (Responsible party) *DATE*

1665 Dominican Way #124
Santa Cruz, CA 95065
(831) 475-7012

BAY EYE MEDICAL GROUP

IMPORTANT PAYMENT INFORMATION

REFRACTIONS

Refraction is the process of determining the eye's refractive error, or need for glasses and / or contact lenses. It is an essential part of an annual eye examination, However: considered a **non-covered** service by Medicare and most insurance companies: Thus, it becomes the responsibility of the patient to pay for the refraction portion of their examination. Our office fee for a refraction is **$60.00**. Please notify the technician and physician if you **do not** want a refraction at the time of service.

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 this service. The co-payment is separate from and not included in the refraction fee.

Signature: _____ Date: _____

BAY EYE MEDICAL GROUP

Contact Lens Fitting Fees:

First Time Contact Lens Wearer:	Soft lenses	$175.
	RGP lenses	$250.
Includes 2 follow-ups	Keratoconus/Post Surgical	$450.

Any Additional Follow Up Visit:	Soft	$ 50.
	RGP	$ 65.

Current Contact Lens Wearer:

Evaluation Fee:	Soft	$50.
	RGP	$65.
Fee for changing lens material or type:	Soft	$80.
	RGP	$100.

Signature: _____ Date: _____