PATIENT INFORMATION: Today's Date ____________________

Last Name ____________________ Legal First Name ___________________ MI _____ Race _____________

Date of Birth ___________ Age ______ Marital Status ___________ SS# ________________ M or F (circle one)

Address ____ Apt # ________________

City _____________________ State ______ Zip __________ Email ___________________________________

Home # ______________________ Cell # _______________________ Work # _________________________

Employer Name _________________________________ City ___________ State ______ Zip ____________

INSURANCE INFORMATION:

- Primary Insurance Carrier _____________________________ Type of Plan: PPO / HMO / HMO / Other

Policy # ____ Group # _______________________________

Policy Holder's Last Name __________________________ First Name ______________________ MI ______

Policy Holder's DOB ________________ SS# ___________________ M or F (circle one)

Patient's Relationship to Insured (circle one) Self / Spouse / Child / Other ________________

- Secondary Insurance Carrier ____________________________ Type of Plan: PPO / HMO / HMO / Other

Policy # ____ Group # _______________________________

Policy Holder's Last Name __________________________ First Name ______________________ MI ______

Policy Holder's DOB ________________ SS# ___________________ M or F (circle one)

Patient's Relationship to Insured (circle one) Self / Spouse / Child / Other ________________

Emergency Contact:

Name ____________________________ Relationship _________________ Phone __________________

Today's Date: ___________________________

Patient Name: ___________________________

DOB: ___________________________

NOTICE REGARDING EYE REFRACTION

REFRACTION POLICY:

Refraction is a diagnostic test that can help determine your eyeglass prescription. A DIAGNOSTIC refraction is required by your insurance company as necessary documentation to evaluate for possible CATARACT SURGERY, however an EYEGLASS refraction is NOT covered by most medical insurances, including Medicare. Our office has a **$75 fee for an eyeglass prescription at the REQUEST of the patient.** If the patient chooses to request an eyeglass prescription in addition to the diagnostic refraction, the fee will be collected along with any co-pays at the time of service. You may choose to file directly with your insurance company with your receipt after check-out.

ACKNOWLEDGEMENT:

I have read the above information and understand that if I choose to request an eyeglass prescription in addition to the diagnostic refraction. I understand that it is a non-covered service. I accept full financial responsibility for the cost of the prescription if I choose to request one, and I understand that my co-pay is a separate cost from the eyeglass prescription.

______________________________ ______________________________________

Patient Name (Printed) Patient or Guardian Signature Date

*In signing this form, please understand you are only ACKNOWLEDGING that you have read and understand the above policy. You are not being charged an eyeglass refraction fee at this time. You will only pay for an eyeglass prescription **if you request one.**

Today's Date: ___________________________

Patient Name: __________________________

DOB: _________________________________

FINANCIAL/INSURANCE POLICY

We have contracted with many insurance carriers or managed care networks to be providers on their plan. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are anxious to help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of valid insurance, you will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurances companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at the time of service.

We must emphasize that filing of claims is a courtesy we extend to all our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW:

I hereby authorize Brooks Eye Associates, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Brooks Eye Associates will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature ____ Date_________________________

Today's Date: ___________________________

Patient Name: ___________________________

DOB: ___________________________

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the NOTICE OF PRIVACY PRACTICES of Brooks Eye Associates
I also consent to the use or disclosure of my protected health information for the following purposes:

a) TREATMENT
It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office, as well as other providers.

b) PAYMENT
Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for the billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

c) HEALTHCARE OPERATIONS
Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.
I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

d) DISCLOSURE OF MEDICAL INFORMATION
Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (example: your spouse or a parent):

1. ____
2. ____
3. ____

____ ___________________________

Patient Name (Printed) Date

____

Patient or Guardian Signature

Today's Date: ___________________________

Patient Name: ___________________________

DOB: ___________________________

PATIENT REFUND POLICY

Brooks Eye Associates strives to collect the accurate amount owed from patients for co-pays, deductibles, co-insurance and advanced technology lenses.

However, on some occasions the patient will be due a refund. In the instance of a required refund, the following policies shall apply:

- Refunds are processed for payment within 30 days of notification from the insurance provider, patient, or explanation of benefits that a refund is due to the patient.
- If the patient paid for services with a debit or credit card, we will process the refund back to that specific card. We will NOT issue checks for credit or debit card refunds.
- If the payment was made with a check or cash, we will provide the refund in the form of a paper check and mail to the patient's last known address.

I (print name) ______________________________ have read the Brooks Eye Associates refund policy and understand how refunds are processed.

____ ______________________

Patient or Guardian Signature Date

Today's Date: ___________________________

Patient Name: ___________________________

DOB: __________________________________

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I (print name) ______________________________ acknowledge that I have received a copy of the Brooks Eye Associates Privacy Practices packet. I understand this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician practice provides this notice to me.

____ ______________________

Patient or Guardian Signature Date

Today's Date: ____________________________

Patient Name: ____________________________

DOB: ____________________________________

Referred by: ______________________________________ Optometrist: ______________________________________

What is the reason for your visit today? ____

____

History of <u>EYE SURGERY</u>? (Circle One) YES or NO

		Right Eye	Left Eye
☐ Cataract Surgery	Dates	_____________	_____________
☐ Cornea Surgery	Dates	_____________	_____________
☐ Glaucoma Surgery	Dates	_____________	_____________
☐ Refractive Surgery (LASIK, PRK, RK)	Dates	_____________	_____________
☐ Retinal Surgery	Dates	_____________	_____________
☐ Strabismus (Muscle) Surgery	Dates	_____________	_____________
☐ Vitreous Surgery	Dates	_____________	_____________
☐ Other	Dates	_____________	_____________

<u>History of EYE DISEASES or problem?</u> (Circle One) YES or NO

(Examples: Glaucoma, macular degeneration, iritis, or dry eye syndrome)

If yes, explain: ____

List current eye drops being used: ____

Do you wear contact lenses? (Circle One) YES or NO If yes, are they SOFT or HARD lenses? ________________

Family history of eye disease? (Circle One) YES or NO If yes, please explain: ___________________________

<u>Major Surgeries</u> within the last 10yrs: ____

<u>Social History:</u>

Smoking:
- ☐ Current Everyday Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Smoker, Status Unknown
- ☐ Unknown if ever Smoked

Type of Tobacco:
- ☐ Cigarettes
- ☐ Cigar
- ☐ Pipe
- ☐ Electric Cigarettes

Alcohol:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Alcohol:
- ☐ Beer
- ☐ Liquor
- ☐ Wine

Recreation Drugs:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Drug:
- ☐ Amphetamines
- ☐ Cocaine
- ☐ IV Drugs
- ☐ LSD
- ☐ Marijuana

Occupation:
- ☐ Business
- ☐ Manual Labor
- ☐ Office Work
- ☐ Retired
- ☐ Student
- ☐ Teacher
- ☐ Driver/Pilot
- ☐ Engineer

Hobbies:
- ☐ Computers
- ☐ Music
- ☐ Sewing/Crafts
- ☐ Sports
- ☐ Travel
- ☐ Golf
- ☐ Hunting
- ☐ Reading
- ☐ Cards
- ☐ Other __________

Primary Care Provider: ________________________________ Phone: ___________________________

Preferred Pharmacy: ____________________________ Street or Intersection: ___________________________

City: _________________________ Phone: ___________________________

BROOKS EYE
ASSOCIATES

Today's Date: ______________________________

Patient Name: ______________________________

DOB: ______________________________________

Please list any drug allergies.

☐ No Known Drug Allergies

Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:

List ALL medications you are currently taking including prescription, OTC, as needed, vitamins, topicals, and supplements.

Medication Name	Dosage

9955 Gillespie Dr, Suite 100 | Plano, TX 75025 | P: 972-403-1110 | F: 972-403-1153

BROOKS EYE ASSOCIATES

Today's Date:____________________________

Patient Name: ____________________________

DOB: __________________________________

Lifestyle Vision Assessment

Dr. Dain Brooks, strives to provide the best quality of care and customized vision solutions for his cataract and refractive lens exchange. This form will assist him in helping you to choose the treatment best suited for your visual needs and lifestyle.

Name: _____________________________ Date: _______________

1) What are your favorite hobbies? ____

2) If you are working, what is your occupation and some of your daily work-related tasks?
____

3) If Dr. Brooks determines that you are an appropriate candidate for the advanced technology currently available, would you be open to hearing about an implant that could significantly reduce or possibly eliminate your need for glasses? ☐ YES ☐ NO

4) If you had to wear glasses/contact lenses after surgery for one activity, for which activity would you be most willing to use glasses/contact lenses?
☐ Reading Fine Print ☐ Computers ☐ TV/Driving

5) How would you describe your personality?
☐ Easy Going ☐ In between ☐ Meticulous/Detailed

It is important to understand that some people still need to wear glasses for certain activities after surgery.

BROOKS EYE ASSOCIATES

Today's Date: ___________________________

Patient Name: ___________________________

DOB: ___________________________

Review of Symptoms

Eyes:

Previous Eye Surgery	□ YES □ NO
Contact Lens Wear	□ YES □ NO
Pain	□ YES □ NO
Double Vision	□ YES □ NO
Glaucoma	□ YES □ NO
Cataracts	□ YES □ NO
Macular Degeneration	□ YES □ NO
Dry Eyes	□ YES □ NO
Flashes	□ YES □ NO
Floaters/Curtains in Vision	□ YES □ NO

Ear, Nose, & Throat:

Hard of Hearing	□ YES □ NO
Ringing in Ears	□ YES □ NO
Vertigo	□ YES □ NO

Cardiovascular:

Chest Pain	□ YES □ NO
Dizziness	□ YES □ NO
Fainting Spells	□ YES □ NO
Shortness of Breath	□ YES □ NO
Irregular Heartbeat	□ YES □ NO
Difficulty Lying Flat	□ YES □ NO
Bypass/Stents	□ YES □ NO
High Blood Pressure	□ YES □ NO

Constitutional:

Fatigue/Weakness	□ YES □ NO
Fever	□ YES □ NO
Weight Gain/Loss	□ YES □ NO

Respiratory:

Cough	□ YES □ NO
Congestion	□ YES □ NO
Wheezing	□ YES □ NO
Asthma	□ YES □ NO
COPD/Emphysema	□ YES □ NO
Oxygen Use	□ YES □ NO

Gastrointestinal:

Heartburn	□ YES □ NO
Nausea/Vomiting	□ YES □ NO
Jaundice/Hepatitis	□ YES □ NO
Irritable Bowel Syndrome	□ YES □ NO
Crohn's/Ulcerative Colitis	□ YES □ NO

Genito-Urinary:

Pain/Difficulty Urinating	□ YES □ NO
Blood in Urine	□ YES □ NO
History of Kidney Stones	□ YES □ NO
History of STD's	□ YES □ NO
Prostate Issues	□ YES □ NO
Kidney Disease	□ YES □ NO

BROOKS EYE ASSOCIATES

Today's Date: ____________________________

Patient Name: ____________________________

DOB: ____________________________________

Review of Symptoms

Psychiatric:

Anxiety/Depression ☐ YES ☐ NO

Mood Swings ☐ YES ☐ NO

Difficulty Sleeping ☐ YES ☐ NO

Endocrine:

Increased Thirst ☐ YES ☐ NO

Increased Hunger ☐ YES ☐ NO

Increased Urination ☐ YES ☐ NO

Increased Sweating ☐ YES ☐ NO

Fingernail Changes ☐ YES ☐ NO

Diabetes Mellitus ☐ YES ☐ NO

Thyroid Disease ☐ YES ☐ NO

Blood/Lymphnodes:

Easy Bruising ☐ YES ☐ NO

Gums Bleed Easily ☐ YES ☐ NO

Prolonged Bleeding ☐ YES ☐ NO

Heavy Aspirin Use ☐ YES ☐ NO

Anemia ☐ YES ☐ NO

Musculoskeletal:

Stiffness ☐ YES ☐ NO

Arthritis ☐ YES ☐ NO

Joint Pain/Swelling ☐ YES ☐ NO

Mobility Restrictions ☐ YES ☐ NO

Joint Replacement ☐ YES ☐ NO

Skin:

Rash/Sores ☐ YES ☐ NO

Lesions ☐ YES ☐ NO

Hives/Eczema ☐ YES ☐ NO

Neurological:

Seizures ☐ YES ☐ NO

Weakness/Paralysis ☐ YES ☐ NO

Numbness ☐ YES ☐ NO

Tremors ☐ YES ☐ NO

Stroke/TIA ☐ YES ☐ NO

Headaches/Migraines ☐ YES ☐ NO

Immunologic:

Hives ☐ YES ☐ NO

Itching ☐ YES ☐ NO

Runny Nose ☐ YES ☐ NO

Sinus Pressure ☐ YES ☐ NO

Lupus ☐ YES ☐ NO

Multiple Sclerosis ☐ YES ☐ NO

9955 Gillespie Dr, Suite 100 | Plano, TX 75025 | P: 972-403-1110 | F: 972-403-1153

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

BROOKS EYE ASSOCIATES, PLLC
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Privacy Officer, Steve Weihing

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.

We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the

extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

<u>Inmates:</u> We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

<u>Facility Directories:</u> Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

<u>Others Involved in Your Health Care or Payment for your Care:</u> Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. **As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.**

Under federal law, however, **you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.** Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an

explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Steve Weihing** at **(972) 403-1110 or sweihing@brookseyemd.com** for further information about the complaint process.

This notice was published and becomes effective on **June 11, 2019.**

Patient Acknowledgement of Receipt of Privacy Practices

I (print name) _________________________________acknowledge that I have received a copy of the Brooks Eye Associates Privacy Practices packet. I understand this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician practice provides this notice to me.

Patient Signature: __________________________________ **Date**: ____________