Johnson Optometric Associates, PA

ROUTINE VISION INSURANCE AND MEDICAL INSURANCE CONDITIONS

Routine Vision

Your routine vision insurance covers routine care under sponsorship from your employer. Your routine vision insurance may pay for your annual routine eye examination. Your routine eye insurance may or may not pay for the refraction part of the examination. The refraction part of the examination determines your prescription if you were to need glasses or contacts. Your routine vision insurance may or may not cover your expenses if you were to need to purchase eyeglasses or contacts. Contact lens services are additional charges that are non-covered services. We gladly accept your routine vision insurance according to the details of your plan.

Medical Examination

When your examination reveals a medical eye diagnosis (ie. glaucoma or red eye) or a medical diagnosis with potential consequences for the eye (ie. diabetes) your examination will be filed under your major medical plan. Your copay for a medical examination will be your specialist copay from your medical insurance carrier. We will gladly file your routine vision coverage for the refraction, glasses and/or contacts. According to your individualized plan, this may or may not cover your expenses.

If you have any questions regarding your individualized plan, please do not hesitate to ask one of our staff and we will gladly assist you.

Thank You,

Johnson Optometric Associates, PA

Effective date of notice: 04/01/03

NOTICE OF PRIVACY PRACTICES

Johnson Optometric Associates, P.A.
918 Seventh Avenue Garner, NC 27529
919-779-3560
(Fax) 919-779-5773

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what right you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medication and faxing them to be filled; showing you low vision aids, referring you to another doctor or clinic for eye care of 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 though a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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 disclosure for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized governmental functions, such as for the protection of the president or high ranking 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' who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will share also relevant information about your eye care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment on a post card, and/or call you. It may be necessary to leave a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosures. If you do sign one, you may revoke it at anytime unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the bottom of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to preview or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for amendment, to the office contact person at the address and fax shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax at the beginning of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact at the address or fax at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Privacy Practice until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

COMPLAINTS

If you think that we have not properly respected the privacy information, you are free to complain to us or the US Dept. 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 Office Manager either at the address or fax at the beginning of the notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address at the beginning of this notice.

This privacy statement represents the policies of Dr. Robert L. Johnson, Dr. Rick L. Hartman, Dr. Robert S, Hammond, and all the staff of Johnson Optometric Associates, P.A.

Dr. Robert L. Johnson
Dr. Rick L. Hartman
Dr. Robert S. Hammond
Dr. Barrett Martin
Dr. Andrew R. May

Johnson Optometric Associates P.A.
1340 N. Main Street
Fuquay Varina, NC 27526
Ph: 919.552.3181
Fax: 919.552.0197

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please be advised that our staff cannot speak with anyone that is not listed on this form. This includes spouses, children, and caregivers.)

______________________________ ______________________
Print Patient Name Date of Birth

I am authorizing the personnel at Johnson Optometric Associates to leave medical information and test results with others if I am not available.

________ I do not wish to have my information released to anyone besides myself.

OR

________ I authorize that my information can be left with my spouse/significant other or parents.

Name of person____________________________

________ Other: I authorize that my information can be left with:

______________________________/______________________
Name Relationship

______________________________/______________________
Name Relationship

Signature:________________________________ Date:______________

Relationship to patient:______________________

FAMILY HISTORY	YES	NO	RELATION	FAMILY HISTORY	YES	NO	RELATION
Blindness				Diabetes			
Cataract				Heart Disease			
Glaucoma				High Blood Pressure			
Macular Degeneration				Kidney Disease			
Retinal Detachment				Stroke			
Cancer				Thyroid Disease			
Other							

Please explain condition(s): ____

____

____

PERSONAL HISTORY	YES	NO	PERSONAL HISTORY	YES	NO
Eyes			**Respiratory (Lungs/Breathing)**		
Cataracts			Asthma		
Eye Surgery/ Eye Injury			Chronic Bronchitis		
Glaucoma			**Gastrointestinal (Stomach, Intestines)**		
Lazy Eye/Crossed Eye			**Genitourinary (Genital/Kidney/Bladder)**		
Macular Degeneration			**Musculoskeletal (Arthritis)**		
Retinal Detachment			**Integumentary (Skin/Breast)**		
Other			**Neurological (Stroke/Numbness)**		
Ears Nose, Mouth, Throat			**Psychiatric**		
Hematological/Lymphatics			**Endocrine**		
Cardiovascular (Heart/Vessels)			Diabetes		
High Blood Pressure			Thyroid		
Heart Disease			**Allergic and Immunological**		

Please explain condition(s): ____

____

____

List current medication(s): ____

____

List any medications you are allergic to: ______________________________

List any surgeries (and date) you have had: ______________________________

____

Occupation: ______________________ **Tobacco Use (type/amount):** ______________

Hobbies: ______________________ **Alcohol Use:** ______________________

Computer Usage: ______________________ **Substance Abuse:** ______________________

Primary Physician: ______________________ **Pharmacy:** ______________________

Date of last Tetanus shot: ______________________

Please print patient's name: ____

Today's date: ______________________

Johnson Optometric Associates, P.A.

Patient Information

First Name________________________________MI_____Last Name_______________________(Jr,Sr,etc)______

Nickname_________________________Birth Date_____________________ SS#________-_________-_________

Sex (circle) M F Marital Status (circle) S M D W Email Address_________________________

Address____________________________City_____________________State__________Zip_________-________

(Phone)Home#_________________________Work#_____________________ext._______Cell#_________________

Employer____Occupation___________________________________

Emergency Contact

Name(First)________________________(MI)___(Last)___________________Relationship__________________

(Phone)Home#________________________ Work#____________________ext.________Cell#________________

Contact Preference

☐ Email ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text/Cell Phone Carrier___________________

Mother's Maiden Name___________________________Patient Birth State___________________

Name of Spouse/Parents(if child)______________________________ Employer_____________________________

Names and ages of other family members who are patients in our office:___________________________________

____

How did you hear about our office? ☐ **Johnson Optometric Asssociates Website** ☐ **Phone Book**
☐ **Patient Referral** ☐ **Insurance Company** ☐ **Other**____________________________________

Insurance Information (Please present card(s) to receptionist)

Insurance Responsible Party

Name_______________________________________ Birth Date________________ SS#______-______-______

Address________________________________ City_______________________ State__________ Zip__________

Payment Information

Payment Policy: Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file for insurance payment when applicable. A charge of 1.5% per month will be added to all accounts 30 days past due. Initial______

Failure to pay balances in the allotted time will result in patient incurring additional costs of collection including, but not limited to attorney or legal fees, collection agency fees and finance charges. Initial______

Acknowledgment

If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to Johnson Optometric Associates, P.A. *Initial*_____

I agree that unless Johnson Optometric Associates, P.A. and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles. *Initial*_____

I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes. *Initial*_____

Signature____**Date**________________________

____

Responsible Party(Parent/Guardian of Minors)

Name_______________________________________ Birth Date________________ SS#______-______-______

Address________________________________ City_______________________ State__________ Zip__________

CONSENT FOR DILATION / OPTOMAP RETINAL IMAGING

We recommend Dilation OR Optomap Retinal Imaging each year. This allows for a more thorough examination of the health of the inside of the eye. Although the Optomap Retinal Imaging can be used to image almost the entire retina without using any eye drops, the Doctor may still need to dilate your eyes if you have certain pre-existing medial conditions such as Diabetes, or other visual symptoms in which the standard of care is to dilate your eyes.

To dilate the pupil, eye drops must be administered. Once your pupils are dilated, it is common to experience sensitivity to light and blurred vision especially at near. It will require 4-6 hours for your vision to return to normal. We will provide a complimentary disposable pair of sunglasses to help alleviate your sensitivity to light. We also recommend that you exercise caution when walking down steps, driving a vehicle, operating machinery, or performing other tasks that may present a risk of injury. If you have any transportation needs, please let us know so they can be arranged.

DILATION CONSENT

YES	NO
______________ I understand the side effects and benefits of pupillary dilation, and I consent to have the procedure performed.	______________ I understand the side effects and benefits of pupillary dilation, and I DO NOT consent to have the procedure performed.

OPTOMAP RETINAL IMAGING CONSENT

YES	NO
______________ I want to have Optomap Retinal Imaging performed. I understand there is a $39.00 charge that is not covered by insurance.	______________ I do not want Optomap Retinal Imaging peformed today. I understand this technology may allow for earlier detection of ocular/systemic disease.

Patient's Name________________________ **Signature**________________________ **Date**___________

HIPAA Privacy Statement

This privacy statement represents the policies of Dr. Robert L. Johnson, Dr. Rick L. Hartman, Dr. Robert S. Hammond, Dr. Andrew R. May, Dr. Barrett K. Martin, and the staff of Johnson Optometric Associates, P.A.

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the privacy statement of Johnson Optometric Associates, P.A.

Patient's Name________________________ **Signature**________________________ **Date**___________