GREGORY A. STAINER, MD FACS • SUNNY SINGH WALIA, MD MBA • JACK GROVES, OD • NHAN LE, OD

215 CHINA GRADE LOOP • BAKERSFIELD, CA 93308 • 661-393-2331   4649 PLANZ RD. • BAKERSFIELD, CA 93309 •661-393-2331

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy rule was also created in order to provide the standard for certain healthcare providers to obtain their patient's consent for uses in disclosures for health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate and necessary, we provide the necessary information to only those whom we feel are in need of minimum healthcare information about treatment, payment, or healthcare operations in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your medical records. We may have indirect treatment relationships with you (such as but not limited to: laboratories that only interact with physicians not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal healthcare information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document at some future time, you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our office staff or our HIPAA compliance officer.

You have the right to review our policy notice, to request restrictions, and to revoke consent in writing after you have reviewed our policy notice.

__________________	____________________________	_____________	____________________
Print Name	Signature	Date	Witness

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ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items of services. We expect that insurance will not pay for the item(s) that are described below. Insurance does not pay for all of your health cost. Insurance only pays for covered items and services when insurance rules are met. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor has recommended it. Right now, in your case, insurance will not pay for the following items:

Items/Services

1. Routine eye refraction or check for glasses (92015) Fee: $50.00
2. Routine eye glasses and contact lenses, except after cataract surgery.
3. Cosmetic eyelid surgery.
4. Femtosecond laser assisted cataract surgery. Fee $530- $1700.
5. Emergency services. (99050, 99051, 99053, 99058, 99060, fee- $50.00)
6. Laboratory testing.
7. Glaucoma Stents.
8. Cataract Surgery.
9. Premium Lens Implants. Fee: $650- $1500
10. Toric Lens.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand, why insurance probably won't pay for these items and services. The above items and services are an estimated cost and most likely if insurance does not pay for these services, your secondary insurance will not pay for these services either.

✓ **YES, I want to receive these items or services, if needed.** I understand that insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to insurance. I understand that you may bill me for items or services and that I may have to pay the bill while insurance is making its decision. If insurance does pay, I understand that I will be refunded any payments that I have made to the office. If insurance denies payment, I agree to be personally and financially responsible for payment. That is, I will pay personally, out of pocket, until I can appeal insurance decision.

SIGNATURE: ____

DATE: ____

NOTE: Your health information will be kept confidential. Any information that we collect about you will be kept strictly confidential. If a claim is submitted to insurance your health information on this form may and will be shared with insurance. Your health information which insurance sees will be kept strictly confidential by insurance.

This form will remain in effect from the above date until canceled by you, the patient.

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OFFICE PROCEDURES AND POLICIES

Welcome to the eye clinic. We aim to provide quality eye care in the setting of meeting the many diverse needs of our patients. The terms of the office's HIPAA policy and ABN are outlined on the prior pages; below we have outlined the office policies, we ask that your review and sign prior to your appointment or receiving care.

1. **Email:** Email is often the best form of communication for many patients. Your acknowledgement below recognizes and allows us to email you directly with information about your eye health.

2. **Missed Appointments:** Due to our commitment to accommodate all patient, we ask that if you are not able to keep your scheduled appointment, that you cancel no later than 24 hours in advance. Any failure of notification, we may apply a $25.00 missed appointment charge to your account.

3. **Account Balance:** Our primary focus is providing eye care for our patients and sometimes our services will have patients with an account balance. For any outstanding balance, we will give patients a 30-day notice of payment with an invoice and if the balance is not paid within 30-days, we hold the right to debit your credit card on file. Your acknowledgement below gives consent to automatically debit my credit card or debit card on file within my patient profile for all procedure fees, co-payments, cancellation fees or other miscellaneous fees not covered by my health insurance.

4. **Office Contest**: We strongly believe in giving back to the community to make Bakersfield the best place to live and work. We often hold office drawing and contest. No purchase necessary to participate in any contest and if you have won within the last 6-months, we will try to spread opportunity to others so you may be determined ineligible.

5. **Discharging A Patient**: Our patients expect the best from us in knowledge and care; and in return we ask all patients to treat our staff in a respectful manner. If patients are unable to meet this level of common courtesy, we may ask you to seek your eye care at another location that might be better suited for you.

6. **Patient Records:** Your records are yours. We welcome you wanting to know about your health and your eyes. In order to pull your records and provide copies of patient information, you may be asked for a $25-$50 administrative fee. However, patients are always able to access their portal without charge.

I hereby acknowledge my understanding about the office policies and agree to comply with the above policies in order to establish care within the practice. If I determine I would like to formally rescind my agreement, I will do so through a formal written request.

____

Printed Name of Patient

X______________________________ ____________________

Signature Date

____

Relation, if signing on behalf of a patient