EyeHealth Texas

6533 Preston Rd Suite 100
Plano, TX 75024
P: (469) 606-9686
F: (888) 975-0230
W: www.eyehealthtexas.com
E: info@eyehealthtexas.com

# Practice Policies

**Welcome to the EyeHealth Texas. We strive to provide the highest quality of medical care. In an effort to foster a collaborative relationship, we ask that you accept some responsibilities as well. Please read the following policies and acknowledge your understanding by signing below.**

**All co-payments, deductibles and other fees are due at the time of your visit.**

- We accept cash, checks, Mastercard, Visa and American Express.
- Be aware that Medicare and many medical insurance plans do not cover preventative or vision related eye examinations. In such cases, you are responsible for payment.
- We will not make a follow up appointment to see the physician unless your balance has paid or if you have reached a payment plan agreement.

**Authorizations and Referrals**

- As a courtesy, we will assist you with obtaining authorizations for your annual exams with your vision plan, or for surgery. However, you are ultimately responsible for ensuring your visit is authorized prior to your appointment. If an authorization is not obtained, you must recognize that you will be held financially responsible for all costs, or your appointment may be canceled. The office will not retro-authorize visits after the appointment time.
- If you have an HMO and require referral or authorization, please call your insurance or primary care doctor before your appointment to verify if an authorization or referral has been processed. This includes all new patient consults/exams, follow up appointments, and surgical procedures.
- If you have PPO plan, your insurance will be billed as courtesy. You are responsible for any non-covered services, deductibles, or co-insurance amounts.

**Please notify us at least 24 hours in advanced if you need to cancel or change your appointment time.**

- If we know 24 hours ahead of time that you will not be able to make your appointment, then we will be able to accommodate another patient in your time slot.
- **Failure to give us 24-hour notice will result in a fee charged to your account. That amount will be $50.00**
- While we attempt to confirm your appointment a few days prior to your scheduled date, it is your responsibility to remember your appointment time and date.
- Three repeated missed appointments or late cancellations will result in termination of our relationship with you. If you are more than 15 minutes late to your appointment, you may be rescheduled.

**If you have an outstanding balance, you must make a payment at time of visit.**

- We ask that you make a payment on your outstanding balance at each visit
- We cannot schedule further care in the office if you do not make payments on your bill.

**There is a fee to complete forms, including DMV, disability forms or letters.**

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- Please inform the office staff if you have any forms when you arrive, or by phone when you schedule an appointment. The fee for completing paperwork is $35.

## Notice of Privacy Practices

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

By law, we must abide by the terms of this Notice of Practices 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 in our website. This notice applies all paper as well as electronic (Electronic Medical Record) forms of protected health information.

## 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 medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or 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 the health information for payments purposes are: asking you about health or vision plans, or other sources of payment; preparing and sending bills or claims: and collecting unpaid amounts (either ourselves or through 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.

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We routinely use health information inside our offices for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

## Uses and Disclosures without Permission

In some limited situations, law allows or requires us to 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 state or federal law mandates that certain health information be reported for specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notice 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 violation 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 suspected to be a victim of crime; to provide information about a crime at our office; or to report a crime that happened somewhat else
- disclosure to a medical examiner to identify a dead person tor to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- uses and disclosures to prevent a serious threat to health or safety
- 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;

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## 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.

## Disclosures

We will 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 one 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 disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing. Send them to this office.

We do have an office e-mail, info@eyehealthtexas.com that is for general inquiries only. We highly recommend that all patient's not send any personal health information due to the e-mail address not being a secure e-mail account. We recommend that protected health information by presented in person or via a secure fax at (888) 975-0230

## Your Rights About Your 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 the restrictions that you want. To ask for a restriction, send a written request to this office at the address, fax or Email shown at the beginning of this Notice.

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- 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 address. Please note that the email listed above (info@eyehealthtexas.com) is a shared address among office staff. We recommend not sending protected health information to the email address listed above. If you would like electronically communicate with the doctor, a messaging feature is included in the web portal.
- Ask to see or to get photocopies of your health information.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us.
- Get additional paper copies of this Notice of Privacy Practices upon request.

## Complaints

If you think that we have not properly respected the privacy of your health information, you are free to file a complaint to us or the U.S. Department of Health and Human Services, Office of 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 the office contact person at the address, fax, or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## Authorization for the Use or Disclosure of Protected Health Information

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in compliance with your prior Consent. EyeHealth Texas provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I agree that the doctors at EyeHealth Texas may request and use my prescription medication history as well as previous records from other healthcare providers and/or third party pharmacy benefits payers for treatment purposes.

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## Consent for Treatment

I authorize the doctors at EyeHealth Texas to provide me with medical care consistent with reasonable and current community standards. (If patient is under 18 years of age, must be signed by parent and/or legal guardian)

## Dilating Eye Drops Consent Form

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. If you wish to drive, you may wait at our office, permitting operating hours, until you feel comfortable to drive. If you are still feel unsafe driving yourself, you may choose to use a taxi service and leave your vehicle for no more than 24 hours in the parking lot.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctors at EyeHealth Texas and/or assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

## Non-Covered Services and Co-payment Notice

In general, medical insurances coverage is for only medical necessary services. The list below is some of the more common items NOT TYPICALLY COVERED by medical insurances.

**Refraction (To Determine prescription for eyeglasses)**
Most medical insurances plans do NOT pay for the refraction component of your eye exam. If not covered by your insurance, the COST of refraction is **$50.00**. This cost is credited back to you if you choose to purchase eyeglasses at our optical shop using a prescription from EyeHealth Texas. We will still bill your insurance plan for the refraction. In the event it is covered, we will refund your $50.00 back to you and notify you.

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**Copays and Deductibles**
Both of these are due at the time of service.

**I understand that insurance does not typically cover the items detailed on this page, and I am personally responsible for payment of types of services.**

## Financial Responsibility

I, the undersigned below, request that payment of authorized medical insurance benefits be made on my behalf to EyeHealth Texas P.A. for services furnished to me by any provider associated with EyeHealth Texas. I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information needed to determine benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing the information to the insurer or agency shown.

If so determined by written contract between EyeHealth Texas and my medical insurer, then EyeHealth Texas accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the medical insurance carrier. If no contract exists between EyeHealth Texas and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by EyeHealth Texas and the charges for services rendered.

If I represent that I have medical insurance, I accept responsibility of all charges for services furnished to me by EyeHealth Texas in the event that is determined that I was not eligible or authorized to receive such services at the time of service.

If I provide insurance information that is incorrect or invalid, I accept responsibility of all charges for payment for services. I understand that at the time of service, I am responsible for payment in full of any copay, out-of-network visit cost, prior outstanding balances, deductibles, and coinsurances. If I do not pay the due balance at the time of service, I agree that a convenience fee of $40 will be added to my balance.

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If I do not fulfill my financial obligation to EyeHealth Texas, I will be sent written invoices detailing my obligation by EyeHealth Texas P.A. At the discretion of EyeHealth Texas, my account may be referred to a collection agency for failure to clear an outstanding balance. If I am referred to collections, a $100 collections fee will added to my balance due along with any costs (including attorney fees, courts costs, and filing fees) necessary to enforce collection of the amount due.

EyeHealth Texas accepts cash, and credit cards. Personal checks are accepted from established patients and are never accepted for new patients. If a personal check is returned by the bank for any reason, I will be responsible for a returned check fee of $40.00, which includes the bank's returned check fee and office administrative cost for handling the returned check.

EyeHealth Texas processes payments using a secure electronic payment system. EyeHealth Texas reserves the right to charge the payment on file through the electronic payment system for any outstanding balances for services rendered for which the patient is responsible. We will notify you by telephone and in writing to detail the charges prior to processing. In the event payment cannot be processed due to a card expiring or being cancelled, a $30 convenience fee will be added and an updated bill will be sent.