Exceeding Your Expectations

Dr. C. Mark Cowan OD
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1100 North 5th Street
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☐ Mr ☐ Miss ☐ Mrs ☐ Ms. ☐ Dr. ☐ Male ☐ Female

First Name Mi Last Name Preferred Name

Mailing Address City State Zip

Social Security # Date of Birth E-mail address

Home Phone Day Phone Cell Phone

Primary Care Physician: ______________________________

Primary Insurance: ______________________________
Company Member/Sponser ID # Member Date of Birth

Pharmacy: ______________________________

Will You Owe $20.00… *The Refraction Fee?*

A refraction is the test that is performed to determine your eyeglass or contact lens prescription and involves, "Which is better, # 1 or # 2?" Medicare and most other insurance plans consider this to be a routine "vision" or "non-medical" service & is not covered under their medical coverage. Medicare secondary insurance plans will also not pay the charge since it is not a Medicare medical-covered service. The refraction fee of $20.00 is paid by the patient in addition to any co-payments required by your particular plan. Should your plan pay us for the refraction, we will reimburse you accordingly.

*Patients with the Vision Service Plan (VSP) or who have **primary insurance** with Humana Military (Tricare) or Louisiana Medicaid will not be responsible for the $20.00 refraction fee, as these plans pay for a refraction.

☐ I understand my financial responsibility & wish to have the refraction performed.

☐ I refuse the refraction and understand that without it I will be unable to receive a new eyeglass prescription.

I hereby authorize any necessary treatment by the doctors in the practice of Thomas Vision Clinic and agree to be responsible for my financial portion of today's exam including co-pays & the refraction fee of $20.00, should my insurance deem it a non-medical service. I authorize this office to release any information necessary to expedite insurance claims.

Signature / Guardian Signature ______________________________ Date: ______________

Print Guardian Name: ______________________________ Relationship to Patient______________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye 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 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 through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** <u>We are not required to agree to these requests</u>. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

  - was not created by us, unless the person that created the information is no longer available to make the amendment,

  - is not part of the health information kept by or for us,

  - is not part of the information you would be permitted to inspect or copy, or

  - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Please direct all questions, requests or for further information related to the privacy of your health information to our office manager by phone (337)239-2020, by email at tvc2020@gmail.com or by mail P.O. Box 681 Leesville, La, 71496.

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department 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 the office manager at the address or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: September 16, 2013

Medical Information

The following information **must be** completed in its entirety. We are required by federal healthcare regulations to collect this information, to keep it on file and update it on a yearly basis.

Patient Name: ____

Race: ____ ☐ Refuse to specify

Height: ____________ Weight: ______________

1. List your past surgeries. or **None**

____

____

2. List your health problems and treatment medications. **or None**

____

____

____

____

3. List any drug or food allergies. **or None**

____

____

Alcohol consumption:
- Occasional
- Everyday
- Never

Smoking status:
- Occasional
- Everyday
- Never
- Past since ____________

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Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Thomas Vision Clinic and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service for ALL self-pay accounts.

Self-pay accounts are patients who are covered by carriers that the practice does not participate with, or patients without an insurance card on file at the time of service. The undersigned agrees that I am individually obligated to pay the full charges at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform TVC of the current address and phone number for the patient and the responsible party.
- Present **all** current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When TVC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the Responsible Party, understands that TVC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ____

Patient Signature ____ Date ______________

Responsible Party Name (Please Print) ____

Responsible Party Signature ____ Date ______________

Eye & Visual Assessment Form

Reason for your visit? ☐ Glasses ☐ Contacts ☐ Eye Injury ☐ Yearly Eye Health Exam

Eye History

Check all that apply

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Eye Trauma
- ☐ Infections
- ☐ Eye Surgery
- ☐ Diabetic Retinopathy

Family Eye History

Check all that apply

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Color Blindness
- ☐ Blindness
- ☐ Diabetic Retinopathy

Current Visual & Eye Problems

Check all that apply

- ☐ Distance Blurry
- ☐ Up Close reading Blurry
- ☐ Headaches
- ☐ Burning
- ☐ Tearing/watering
- ☐ Dry/Sandy/Gritty feeling
- ☐ Cloudy Vision
- ☐ Floaters/Spots
- ☐ Loss of side vision
- ☐ Loss of vision
- ☐ Light/Glare sensitivity
- ☐ Double vision
- ☐ Color vision

Retinal Exam Option

Retinal problems such as macular degeneration, glaucoma, retinal holes, and systematic diseases such as diabetes, stroke, & high blood pressure develop & progress without warning & can lead to partial loss of vision or blindness.
****These conditions are extremely difficult to detect without dilation or the Optomap Retinal Image.**

Optomap Provides:

- A quick, comfortable, **non-dilated** eye wellness scan
- An in-depth wide view of the retinal layers (where diseases can start)
- The ability to review your images & see what Dr. Cowan sees

****Insurance does NOT cover the Optomap Retinal Imaging fee of $29.00****

Please read & choose ONLY ONE

☐ I choose to have OPTOMAP retinal imaging instead of dilation. I understand I will be responsible for the **fee of $29.00**.

☐ I choose to be DILATED. I understand this is covered by my examination fee at no extra cost.

☐ I choose to have NEITHER the Optomap retinal imaging or dilation. I understand that the doctor will have a limited view of my retina to evaluate for eye diseases and early signs of high blood pressure, diabetes, & other systematic diseases.

______________________________ ______________

Signature Date

Please sign below stating that we, Thomas Vision Clinic, provided you with a copy of our Notice of Privacy Practices.
The Notice included in this packet is for your records.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Thomas Vision Clinic's Notice of Privacy Practices.

Date ______________________

Patient name ____

Signature ____

Guardian Signature ____

Relationship to Patient ____