MATTAX-NEU-PRATER EYE CENTER, INC.
MATTAX-NEU-PRATER SURGERY CENTER, LLC
1265 E. Primrose
Springfield, MO 65804

NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER, 2013

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.

UNDERSTANDING YOUR MEDICAL RECORD/PROTECTED HEALTH INFORMATION

Each time you visit our office, a record is made of your visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your medical record or PHI (Protected Health Information), it serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

YOUR HEALTH INFORMATION RIGHTS

Although your medical record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and copy your medical record as provided for in 45CFR 164.524
- amend your medical record as provided in 45 CFR 164.526
- request an accounting of disclosures of your PHI as provided in 45 CFR 164.528
- request communications of your PHI by alternative means or at alternative locations
- revoke your authorization to use or disclose PHI except to the extent that action has already been taken
- a summary or explanation of uses of PHI that are not described in this pamphlet, made available solely upon receipt of written authorization from you
- an electronic copy of health care records when PHI is maintained in an electronic format
- be notified if a breach of confidentiality occurs that involves your PHI. (The extent of information regarding the breach will vary depending on the nature and extent of the breach)
- request amendments to records when errors are identified

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your PHI for treatment.
Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.
One of the most efficient uses of electronic medical records is for physicians sharing in your care to exchange information.
For example: if you are referred from an ophthalmologist to a specialist, prior information, test results, and photographs can easily be transmitted electronically to you and or the specialist

We will use your PHI for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. For years this has been accomplished with paper via fax, but with electronic records, the information can be sent electronically via a secure connection. Typically, this results in faster payment of the claim.
Agreement for out-of-pocket services
If you elect to pay “out of pocket” for a procedure, service, or visit and request that we ***DO NOT*** disclose this information to a health plan, we must accommodate this request unless required by law to disclose the information.

We will use your PHI for regular health operations.

For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contracts with Business Associates. Examples include but are not limited to diagnostic services, certain laboratory tests, billing and collection agencies, attorneys and accountants. When these services are contracted, we may disclose your PHI to our Business Associates so that they can perform the job we've asked them to do and bill you or our third-party payer for services rendered. In order to protect your PHI we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Organ procurement organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Disaster Relief organizations: Relief organizations may obtain PHI to coordinate your care and/or locate family members in the event of a disaster

Marketing: The privacy rule defines marketing as making “a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.” Generally if the communication meets this definition, then the communication can only occur if we first obtain your authorization. We may NOT sell PHI to a business associate or any third party for that party’s own purpose. We will not sell lists of patients without first obtaining written authorization from each patient on the list. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising Efforts: If and when applicable, you will be contacted prior to sharing information for purposes of fundraising efforts. If fundraising is planned you will also be given the opportunity to “opt out” of receiving fundraising communications.

Food and Drug Administration (FDA): We may disclose to the FDA PHI relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Mattax-Neu-Prater Eye Center, Inc., and Mattax-Neu-Prater Surgery Center, LLC are separate legal entities and the sole purpose of combining them herein is to comply with 45 CFR 164.504 (d).

OUR RESPONSIBILITIES

Our organization is required to:

- maintain the privacy of your PHI
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you in the event of a breach of your PHI
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected PHI we maintain.

We will not use or disclose your PHI without your authorization, except as described in this notice.

FOR MORE INFORMATION

If you have questions and would like additional information, you may contact our privacy official, the Clinic Administrator at (417) 886-3937. If you would like to request a copy of your personal PHI you may obtain those forms from our front desk or download from our website at: **www.mattaxneuprater.com.** Mail completed forms to the Clinic Administrator who will contact you to determine what information you desire and the reason for the request

If you believe your privacy rights have been violated, you can file a complaint with the Clinic Administrator on forms provided or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Mattax-Neu-Prater Eye Center, Inc., and Mattax Neu Prater Surgery Center, LLC, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals, and
- A means by which payment for services can be made.

I understand and have been offered a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and will provide a copy of any revised notice. I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC, unless Mattax-Neu-Prater Eye Center agrees to the request in writing.

I understand that for convenience or necessity I would like my health information available to the following friends or family members. I understand if I choose to not list anyone below, absolutely no information about me, my treatment or my bill may be disclosed to anyone except me.

I consent for the following individuals may have access to the following information:

Name: ______________________________ Relationship: __________________________

☐ All aspects of my care in cluding treatment, diagnosis and billing information
☐ Treatment and diagnosis information ONLY
☐ Billing information ONLY

Name: ______________________________ Relationship: __________________________

☐ All aspects of my care including treatment, diagnosis and billing information
☐ Treatment and diagnosis information ONLY
☐ Billing information ONLY

☐ **I do not wish to have any health or billing information shared. I understand I will need to pay cash for any services rendered on the day they are performed and no insurance companies will be notified or billed.**

I understand that should my circumstances change and I no longer wish the above named to have access to my protected health information, I must contact Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC, immediately.

I fully understand and accept the terms of this contract.

I am a patient or parent / legal guardian of a patient of Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC. I hereby acknowledge receipt of Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC's **NOTICE OF PRIVACY PRACTICES.**

Patient Name (PRINT)____________________________ Date of Birth: ______________

Signature : ___________________________________ Date: ________________

☐ Patient ☐ Parent ☐ Legal Guardian

Health and Medications Information

DOB: ____________________ Date: ____________________

Name: ____________________ Phone: ____________________

Family Physician: ____________________ Referring Doctor: ____________________

DRUG ALLERGY / Reaction: ____________________

Current Medications Dosage / Frequency

____
____
____
____
____
____

Surgical Procedures within last 5 years

____
____
____
____
____
____

YOUR PAST MEDICAL HISTORY

- ☐ Acid Reflux Disease (GERD)
- ☐ Alzheimer's Disease
- ☐ Anemia - Chronic
- ☐ Arthritis - Degenerative (DJD)
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ COPD -Chronic Lung Disease
- ☐ CVA - Stroke
- ☐ Cancer ____________________
- ☐ Cirrhosis / Liver Disease
- ☐ Collagen Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ DVT - Deep Vein Thrombosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes #years_____
- ☐ Dialysis - Hemodialysis
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Graves's Disease
- ☐ HIV / AIDS
- ☐ Other:____________________
- ☐ Head Injury
- ☐ Headache - Chronic
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis B / C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pain - Chronic
- ☐ Peptic Ulcer Disease (PUD)
- ☐ Peripheral Vascular Disease
- ☐ Prostate Enlarged (BPH)
- ☐ Renal Insufficiency - Chronic
- ☐ Restless Legs Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ Anticoagulant Therapy
- ☐ Other:____________________
- ☐ Other:____________________

Eye Problems	Self	Family	
Amblyopia (Lazy Eye)	☐	☐	________
Glaucoma	☐	☐	________
Astigmatism	☐	☐	________
Cataract	☐	☐	________
Choroidal Melanoma	☐	☐	________
Corneal Dystrophy	☐	☐	________
Diabetic Retinopathy	☐	☐	________
High Myopia	☐	☐	________
Macular Degeneration	☐	☐	________
Retinal Detachment	☐	☐	________
Strabismus	☐	☐	________
Other:	☐	☐	________
	☐	☐	________
	☐	☐	________

Family Medical Problems

- Complication of Anesthesia ____________________
- Bleeding (Coagulation) Disorder ____________________
- Cancer ____________________
- Diabetes ____________________
- Heart ____________________
- Hypertension ____________________
- Migraine ____________________
- Rheumatoid Arthritis ____________________
- Stroke ____________________
- Thyroid Disorder ____________________
- Other: ____________________

YOUR SOCIAL HISTORY

	Y	N	Frequency / Type
Do you smoke?	☐	☐	____________
Do you drink alcohol?	☐	☐	____________
Do you use recreational drugs?	☐	☐	____________

Please indicate special living arrangements below:

☐ Nursing home ☐ Skilled nursing facility/floor ☐ Other ____________

Name of facility ____________________

	Y	N
Are you currently pregnant?	☐	☐
Is POA required for consent?	☐	☐
Advanced directive / Living Will?	☐	☐

PATIENT INFORMATION

PLEASE Complete the ENTIRE FORM – Although certain questions may not seem appropriate for this examination, the answers could be important for care in the future.

Patient's FULL Name	Home Phone	Cell Phone

Street Address	City, State	Zip

E-Mail

Gender	Marital Status ☐ Divorced ☐ Married ☐ Other_______ ☐ Single ☐ Widowed	Date of Birth	Social Security No.

Race ☐ Caucasian ☐ African American ☐ American Indian/Eskimo/Aleut ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other ______________	Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	Preferred Language ☐ English ☐ Spanish ☐ Other_______

Employer (Name/Address)	Employer-Phone	Occupation

Spouse's FULL Name	Occupation
Spouse's Employer (Name/Address)	Employer-Phone

If Patient is MINOR, Father's Name	Employer-Address	Employer-Phone
Mother's Name	Employer-Address	Employer-Phone

Referred to This Office by: Doctor's First and Last Name	Clinic Name	Phone
Primary Care Physician: Doctor's First and Last Name	Clinic Name	Phone

How Referred:

☐ Self ☐ Yellow Pages ☐ Family/Friend ☐ TV ☐ Newsletter ☐ Newspaper ☐ Radio ☐ Building Sign

IMPORTANT: Please list the name of someone **not living at home** that would be willing to take a message for you in case we could not reach you at home or work. THIS COULD SAVE YOU A TRIP TO THE OFFICE IF THE DOCTOR IS CALLED OUT ON THE DAY OF YOUR NEXT APPOINTMENT.

Name	Relationship to Patient

Email	Home Phone	Cell Phone	Work Phone

1. INSURANCE CO. ______________________ POLICY # ______________ GROUP # ______________

____

Mailing Address City State Zip

Policyholder ______________________ Birthdate ______________ Soc. Sec. # ______________

Is this person still working? ________ Retired? ________ How Related ______________________

2. INSURANCE CO. ______________________ POLICY # ______________ GROUP # ______________

____

Mailing Address City State Zip

Policyholder ______________________ Birthdate ______________ Soc. Sec. # ______________

Is this person still working? ________ Retired? ________ How Related ______________________

Assignment of Benefits and Authorization to Release Information: I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier, to be made on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or the listed responsible person(s), any information needed to determine benefits for the other related services.

Financial Agreement: I accept responsibility for providing correct insurance information at the time of my appointment. I also accept full financial responsibility for all charges not covered by insurance and/or filed with incorrect insurance provided by myself or responsible billing party. I understand that I am responsible for the costs of collection including attorney fees and court costs.

______________________ ____

Date Signature of patient (if patient is a minor a parent's signature is required)

MATTAX NEU PRATER EYE CENTER

REQUEST FOR ACCESS TO / RELEASE OF MEDICAL INFORMATION

According to Federal Law form must be filled out completely before we accept it, changes may not be made after it is signed

Patient Name:____

Date of Birth:_____/_____/__________Phone:_________________________________

Address:____________________________City:___________________State:_______Zip:________

We will provide you with the last calendar year of visits unless otherwise specified.
I, the undersigned, authorize and request Mattax Neu Prater Eye Center to: **(check one)**

☐ RELEASE RECORDS TO ☐ OBTAIN RECORDS FROM

Name:______________________________Phone:______________________Fax:_______________

Address:____________________________City:___________________State:_______Zip:_________

Is a Patient Visit Summary Letter acceptable? **(Circle one)** ☐ YES ☐ NO

OR Do you wish to: **(check one)**

☐ Arrange an appointment to inspect the requested information?

☐ Receive a copy of the requested information?

Instructions regarding copies: **(check one)**

☐ I will pick up the copies

☐ MAIL ☐ FAX copies

Specific Health Care Information requested: If additional records are required from what is provided standard, please provide the details and dates below.____

____

This Request was signed by: ____
Signature Printed Name – Patient or Representative

Relationship to Patient (if other than patient):__________________________________ Date: ___/___/___

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. The Practice may limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

-For Office Use Only- **Approved date:** **copy of PHI released to patient date:** **Denied date:** **letter of explanation sent to patient date:**

ID Confirmed: __________ **Received by:** __________ **Date:** ___________________________