Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group
Notice of Privacy Practices

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 Health Record Information

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- 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 that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of information for public health officials charged with improving the health of the regions that they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health record and how your health information is used helps you to—

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment,

payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
  - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
  - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
  - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
  - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.
  - Information that is copyright protected, such as certain raw data obtained from testing.

  In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
  - A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
  - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
  - The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

- Obtain an accounting of nonroutine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures for treatment, payment, and health care operations under certain circumstances, primarily if we maintain an electronic health record. We do not need to provide an accounting for the following disclosures:
    - To you for disclosures of protected health information ("PHI") to you.
    - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care of your location, general condition, or death).
    - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
    - That occurred before April 14, 2003.

  We must provide the accounting within 60 days. The accounting must include the following information:
    - Date of each disclosure.
    - Name and address of the organization or person who received the protected health information.
    - Brief description of the information disclosed.
    - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

  The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.
- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. These include most uses or disclosures of psychotherapy notes, marketing communications, and sales of PHI. Other uses and disclosures *not described in this notice* will be made only with your written authorization.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

- **We may use your health information for treatment.**
  Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **We may use your health information for payment.**
  Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **We may use your health information for health care operations.**
  Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide. Note that some health information, such as substance abuse treatment information, may not be used or disclosed without your consent.

- **Business associates.**
  We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.

- **Directory.**
  Unless you notify us that you object, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

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

- **Communication with family.**
  Unless you object, we, as health professionals, using our best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.

- **Research.**
  We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- **Funeral directors.**
  We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

- **Marketing/continuity of care.**
  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. If we contact you to provide marketing information for other products or services, you have the right to opt out of receiving such communications. At Price Vision Group**,** we leverage cookie-based technology to group users into re-marketing audiences who have expressed an interest in our procedures by accessing key pages throughout our website. We do not collect any personally identifying information with this cookie. Audience members may be shown Price Vision Group text and/or image ads on 3rd party Internet sites for a limited period of time. Visitors may opt out of re-marketing by changing their Internet Ad Settings.

- **Fundraising.**
  We may contact you as a part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials.

- **Food and Drug Administration (FDA).**
  We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.

- **Workers compensation.**
  We may disclose health information 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.

- **Public health.**
  As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Correctional institution.**
  If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

- **Law enforcement.**
  We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- **Health oversight agencies and public health authorities.**
  If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the Department of health.

- **The federal Department of Health and Human Services (DHHS).**
  Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Contact Information:
Privacy Officer
Price Vision Group
9002 N. Meridian St, Ste 100
Indianapolis, IN 46260

Phone: 800-317-3937
Email: info@pricevisiongroup.net

Effective date: April 1, 2016

Name of covered entity: Corneal Consultants of Indiana, Inc., d/b/a Price Vision Group

Corneal Consultants of Indiana d/b/a Price Vision Group

Acknowledgment

I hereby acknowledge that Corneal Consultants of Indiana made available to me a copy of their Notice of Privacy Practices.

_____ _____

Patient or Patient's Representative **Date**

_____

Representative's Relationship to Patient

Patient refused to sign:

_____ _____

Employee **Date**

Price Vision Group

9002 N. Meridian Street, Suite 106A
Indianapolis, IN 46260-5349
(317) 814-2933
www.pricevisiongroup.com

Patient Information Record

Name of Patient: _____ Date: _____

Address: _____City: _____ State: _____ ZIP: _____

Home #: _____ Work #: _____ Alternate #: _____

Personal E-Mail Address: _____

Business E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Marital Status: ☐ Single ☐ Married

Occupation (if retired, previous occupation): _____

Employer: _____

Employer Address: _____

_____

Emergency Contact

Name: _____ Telephone #: _____

Name of Family Physician: _____

You, as the patient, will be expected to pay our stated fees. In all cases, the patient will have to pay our fees in full prior to examinations and surgery and file the claim themselves to recover whatever the insurance company will pay, if anything.

I have read the above and understand that I will be responsible for payment of any part of my VISION CORRECTION examinations and surgery and that such balance is due at the time of service.

_____

Signed by Printed Name Date

Price Vision Group

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Patient History

Name of Patient: _____

Why are you interested in refractive surgery? (Check all that apply)

- ☐ Decrease dependency on glasses or contacts
- ☐ Unable to wear contact lenses
- ☐ Appearance or fashion
- ☐ Work related reasons
- ☐ Improved self-image
- ☐ Undecided

How did you hear about us? (Check all that apply)

- ☐ Friend (Name?)
- ☐ Family (Name?)
- ☐ Patient (Name?)
- ☐ Eye Doctor (Name?)
- ☐ Other Doctor (Name?)
- ☐ Internet Search
- ☐ Social Media
- ☐ Event/Fair (Name?)
- ☐ Newspaper
- ☐ Radio
- ☐ Seminar
- ☐ Television

Write name here: _____

Other: _____

Check the box for YES to each of the following if you currently have:

- ☐ AIDS or HIV exposure
- ☐ Cataracts
- ☐ Epilepsy
- ☐ Retinal Detachment History
- ☐ Pregnant or Nursing
- ☐ Diabetes or Hypoglycemia
- ☐ Glaucoma
- ☐ Stroke or Vascular Disease
- ☐ Autoimmune Disease
- ☐ Dry Eyes
- ☐ Rheumatoid Arthritis
- ☐ History of Herpes Simplex Eye Disease
- ☐ Family History of Keratoconus or Corneal Transplant
- ☐ Taking Aspirin, Blood Thinners, Cortisone
- ☐ Exposed, infected or in close contact with MRSA (Methacillin Resistant Staph Aureus) or MRSE (Methacillin Resistant Staph Epidermidus)

Please explain any YES answers above or any information we should be aware of prior to your surgery:

_____

_____

_____

List all allergies	**List all medications**	**Strength**	**Dosage**
_____	_____		
_____	_____		
_____	_____		

Have you previously had any problems taking the following:

Darvocet (propoxephene) - narcotic pain medication
☐ No ☐ Never taken ☐ Yes (explain) _____

Restoril (temazepam) - sleeping medication
☐ No ☐ Never taken ☐ Yes (explain) _____

Valium (diazepam) - mild sedation medication
☐ No ☐ Never taken ☐ Yes (explain) _____

Last eye exam (date and location) _____

Did they refer you here? ☐ Yes ☐ No

How long since you've last worn your contact lenses? _____

☐ Soft ☐ Hard ☐ Gas-permeable

Have you been out of the country in the last year? ☐ **YES** ☐ **NO**

If yes, please list location: _____

Check the box for YES to each of the following:

SKIN
- ☐ Eczema
- ☐ Rashes in last 6 months
  Location: _____
- ☐ Ulcers (legs)

EYES
- ☐ Eye disease
- ☐ Glaucoma

RESPIRATORY
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure

PSYCHIATRIC
- ☐ Nervous breakdown

GASTROINTESTINAL
- ☐ Hernia
- ☐ Stomach trouble
- ☐ Ulcers (stomach)
- ☐ Ulcers (duodenal)

GENITOURINARY
- ☐ Hemorrhoids
- ☐ Kidney disease
- ☐ Venereal disease

MUSCULOSKELETAL
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Swollen/red joints

NEUROLOGICAL
- ☐ Chronic headaches
- ☐ Epilepsy
- ☐ Neuritis

LIST OTHER ILLNESSES

_____
_____
_____
_____

ENDOCRINE
- ☐ Autoimmune disease
- ☐ Cancer-tumors
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Gout
- ☐ Liver disease
- ☐ Pancreatitis
- ☐ Thyroid disease
- ☐ Unexplained weight loss/gain

HEMATO-IMMUNOLOGIC
- ☐ Exposure to AIDS
- ☐ Positive HIV
- ☐ Chicken pox
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Rheumatic fever
- ☐ Bleeding tendencies
- ☐ Exposure to MRSA
- ☐ Exposure to MRSE

EYE SURGERY/OPERATIONS	MONTH-YEAR	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER OPERATIONS	MONTH-YEAR	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

		IF LIVING HEALTH STATUS				IF DECEASED	
Family	**Age**	**Good**	**Fair**	**Poor**	**Known illnesses**	**Age at death**	**Cause of death**
Father	____	☐	☐	☐	_____	____	_____
Mother	____	☐	☐	☐	_____	____	_____
Siblings	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____

Patient Signature _____ **Date** _____

Price Vision Group

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Email Communication Consent Form

PATIENT:

_____ _____
Name of Patient/Previous Names Birth Date

_____ _____
Street Address City, State, Zip Code Current Email Address

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with the practice via email without understanding and accepting these risks. This consent authorizes Price Vision Group and its affiliated health care providers (all referenced here as "PVG") to communicate with me using open internet email channels. The specific email address that I am currently using is noted above. However, this consent allows PVG to communicate with me using any email address that I provide to PVG, and/or any email address that I send communications to PVG.

I understand that PVG offers Patient Portal, a secure encrypted communications tool where I can access portions of my medical record. I agree to establish a Patient Portal account (offered at no cost to all patients at https://portal.pricevisiongroup.net). Confidential patient information should ordinarily only be exchanged through Patient Portal or other secure communication devices. Open email exchanges should generally be limited to communications that do not contain sensitive patient information.

I authorize PVG to notify me of appointments by email appointment reminders. In addition, I authorize PVG to share information about its programs and services offered in the community, including programs or services specific to me, using email communications. I may also receive patient surveys, promotional offers or information about PVG charities and fundraising programs.

I understand that I can "opt out" of the use of email as a means of communication by sending an email to PVG at marketing@multicare.org or by calling (800)317-3937. I understand that some messages already scheduled for delivery may be sent after I opt out, and I authorize PVG up to ten business days to fully process my opt-out request.

The risks include, but are not limited to, the following:
- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of using email
Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however; we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication. Consent to use email includes agreement with the following conditions:
- Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access the medical record/email (e.g. billing staff).
- Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. Our employees will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from the patient, it is not guarantee that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time- sensitive matters.
- If the patient's email invites a response from the provider and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.

I have read and understand the risks of using email and agree that email messages may include protected health information about me or the patient named below (if I am signing as the patient's representative).

PATIENT SIGNATURE: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

PVGEMAILRELEASE Rev 3.8.19

Price Vision Group

9002 N. Meridian Street, Suite 106
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www.pricevisiongroup.com

Insurance Coverage For Laser Vision Correction

At the present time very few health insurance plans cover refractive surgery (LASIK) due to the fact that this is an **elective** procedure. This means that your refractive error is able to be corrected non-surgically. Therefore, you will be expected to pay for your surgery in full at the stated fees.

If you have LASIK coverage with your insurance carrier, we will supply the necessary information for you to submit to your insurance carrier, upon request.

Our normal fees include post-operative care and free enhancement within the one-year period upon completion of post-operative care (unless otherwise directly stated).

No insurance will be filed for exams, testing, procedures, or any other services provided by Price Vision Group Refractive Clinic.

Your cooperation is appreciated.

The Doctors and Staff of Price Vision Group

☐ **I have read the above and understand that I will be responsible for payment of all fees from my elective refractive surgery.**

☐ **I have read the above and declare that I am responsible for payment of all exam and testing fees in full at the time of service. If a medical diagnosis is found, a referral will be made to an appropriate provider.**

Patient Signature **Patient Name Printed** **Date**