CARY EYE CENTER, PLLC.

PERSONAL INFORMATION - PLEASE PRINT					
PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)			BIRTH DATE	AGE	SEX M F	MARITAL STATUS M W D S
PATIENT ADDRESS					
ZIP CODE	CITY	STATE	EMAIL ADDRESS		
PREFERRED LANGUAGE		SOCIAL SECURITY #			
DRIVER'S LICENSE #			STATE		
HOME PHONE	WORK PHONE		CELL PHONE		
PREFERRED METHOD OF CONTACT	□EMAIL	□TEXT	□ PHONE		
CURRENT EMPLOYER/SCHOOL		OCCUPATION/GRADE			
Emergency Contact		Phone#	Relationship to patient		
REFERRING PHYSICIAN					

RACE □American Indian or Alaska Native □Asian □Black or African American □White □Other
□Native Hawaiian or Other Pacific Islander

ETHNICITY □Hispanic or Latino □Not Hispanic or Latino

WHOM MAY WE THANK FOR REFERRING YOU?

How did you hear about our practice? □Web Search/Internet □CEC Website □Friend □Insurance Company □Other

INSURANCE INFORMATION	please fill in all isurance information.				
VISION INSURANCE	MEMBER NUMBER	GROUP#	CARD HOLDERS NAME	CARD HOLDERS DOB	
PRIMARY MEDICAL INS.	MEMBER NUMBER	GROUP#	GROUP NAME	EFFECTIVE DATE	CARD HOLDERS DOB
SEC MEDICAL INS	MEMBER NUMBER	GROUP#	GROUP NAME	EFFECTIVE DATE	CARD HOLDERS DOB

Authorization to Release Assign Insurance Benefits: I understand that I am financially responsible to Cary Eye Center for charges. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court cost incurred in attempting to collect on the outstanding balance. **Accounts not paid within 90 days are subject to a 12% monthly finance charge.**

Office Financial Policies: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. For your convenience, we offer the following methods of payments:

CASH CHECK MASTERCARD VISA DISCOVER

*****There is a $35.00 fee for a check returned by the bank for any reason*****

Missed Appointment Policy: If you must cancel your appointment, please do so at least one (1) business day in advance or you may be charged a **$50.00 No Show Fee.**

Your signature below signifies your understanding, acceptance and agreement to our office policies.

Responsible Party Signature

Date

Cary Eye Center
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Financial Policies and Procedures

Thank you for choosing us as your Ophthalmology/Eye Care Specialists. We are committed to your care being successful. The following is a statement of **FINANCIAL POLICIES** AND **OFFICE PROCEDURES** which we require you to read and sign.

APPOINTMENTS

Please arrive 30 minutes prior to your appointment time(FOR NEW PATIENTS) to update paperwork more than six months old or 15 minutes prior to your appointment for returning patients to update paperwork.

MISSED APPOINTMENTS/CANCELLATIONS

Our policy is to charge for missed appointments or appointments cancelled with less than 24 hours' notice at a rate of $50.00 per appointment.

CO-PAYMENTS, DEDUCTIBLES AND FEES

Co-payment, insurance deductibles and fees for service not covered by your insurance policy are collected at the time service is rendered. We accept personal checks, VISA, MASTERCARD, and DISCOVER. We do not accept postdated checks. We do expect you to pay any deductible not met or co-insurance you are responsible for. Bills for surgery will not include charges for anesthesia, hospital, facility or laboratory tests. These are billed separately from the facility where they are performed. **Accounts not paid within 90 days are subject to a 12% monthly finance charge.**

REGARDING INSURANCE

We will file insurance for you as a courtesy, provided we are supplied with the proper information. Our office will provide you with proper documentation to file your own insurance, if needed. If you do have health insurance please remember that professional services are rendered and charged to you and not to the insurance company. For insurance plans we are contracted providers for, we will automatically file insurance. **Please be aware that some services provided may be non-covered services or not considered medically necessary under Medicare and/or other medical insurance programs, and you are responsible for the payment of these services.**
If you have been involved in an automobile accident or have any pending legal action we will ask you to pay for services personally or verify subrogation through your health insurance. We do not file third party insurance and we do not wait until settlement for payment.

CONTACT PATIENT FOR BILLING PURPOSES

In order for CEC or its representatives to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MEDICATION REFILLS/AFTER HOURS CONSULTATIONS

Please allow 48 to72 hours to have your prescription refill to be sent to the pharmacy.
For after hour emergencies, please go to your local Urgent Care or ER.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account.

COMPLETION OF FORMS (for Disability, FMLA, DMV, etc)

A fee of $25.00 per form will be charged as patient responsibility for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability and FMLA

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY AND PROVEDURES. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS THIS NEEDS TO BE BROUGHT TO OUT ATTENTION PRIOR TO BEING EXAMINED.

I UNDERSTAND AND AGREE TO THIS POLICY:

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

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Authorization to Release Medical Records

The purpose of this form is to initiate a transfer of medical records so that we may obtain information from your last eye care provider.

Patient's Name _____ **DOB** _____

I request and authorize the following doctor/office to release healthcare information for the patient named above to **Cary Eye Center, PLLC**

100 Parkway Office Ct, Suite 200, Cary, NC 27518
Phone # 919-322-1995 Fax # 919-827-1321

Office _____
Address _____
_____
_____
Phone # _____
Fax # _____

□**Fax Records** □**Mail records**

This request and authorization applies to:

□All Healthcare information (Please send the last 3 visits-we will request more only if needed)
□Healthcare information relating to the following treatments, conditions, or dates:
□All Surgery
□All Lasik Information
□All Cataract Surgery w/Post Op Info
□Last 4 Office Visits
□Most recent Visual Fields

_____ _____
Signature of Patient/Parent/Guardian or Authorized Prepresentative Date

_____ _____
Printed Name of Authorized Prepresentative Relationship

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Cary Eye Center, PLLC. I understand that the revocation will not apply to information that has already been released in repsonse to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise stated, this authorization will expire one (1) year from the date signed.

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Name _____ DOB _____ Date _____

Past Medical History

□Anxiety disorder
□Arthritis
□Asthma
□Atrial Fibrillation(Irregular Heartbeat)
□Benign Prostatic Hypertrophy
□Cerebrovascular accident
□Chronic obstructive lung disease
□Coronary arteriosclerosis
□Depressive disorder
□Diabetes diag year _____
□COVID Infection
□Elevated blood pressure
□End Stage Renal Disease
□Epilesy
□Gastroesophageal reflux disease
□Hypertension
□Hearing Loss
□HIV/AIDS
□Hypercholesterolemia
□Hyperthryoidism
□Hyppthyroidism
□Leukemia
□Malignant Lymphoma
□Malignant tumor of breast
□Malignant tumor of colon
□Malignant tumor of lung
□Malignant tumor of prostate
□Radiation therapy treatment mangement
□Transplantation of bone marrow
□Other _____
□None

Past Surgical History

□Aabdominoperineal resection
□Bilateral replacement of knee joints
□Biopsy of breast
□Biopsy of prostate
□Coronary artery bypass graft
□Entire transplanted kidney
□Excision of basal cell carcinoma
□Excision of melanoma
□Excision of squamous cell carcinoma
□H/O: colostomy
□H/O: tuabl ligation
□History of Appendectomy
□History of bilateral mastectomy
□History of cholecystectomy
□History of colectomy
□Other: _____
□History of liver excision
□History of percutaneous transluminal coronary angioplasty
□History of tissue graft heart valve replace
□History of total cystectomy
□History of transurethral prostatectomy
□Hysterectomy
□Kidney biopsy
□Low anterior resection of rectum
□Lumpectomy of breast
□Mechanical heart valve replacement
□Oophorectomy
□ Pancreatectomy
□Percutaneous extraction of kedney stone
□Portosystemic shunt peration
□Prostatectomy
□Prosthetic arthroplasty of bilateral hips
□Splenectomy
□Surgical biopsy of skin
□Total nephrectomy
□Total orchidectomy
□Total replacement of hip
□Total replacement of knee
□Transplantation of heart
□Transplantation of liver
□Other
□None

Ocular History

□Allergic Conjunctivitis
□Anatomic narrow angle glaucoma
□Blephartis
□Cataract of right eye
□Cataract of left eye
□Contact lens observable
□Corneal dystrophy
□Degenerative disorder of macula
□Elevated right intraocular pressure
□Elevated left intraocular pressure
□Epiretinal membrane of right
□Epiretinal membrane of left
□Glaucoma of right eye
□Glaucoma of left eye
□Narrow Angle glaucoma
□Background diabetic retinopathy
□Ophthalmic Migraine
□Posterior vitreous detachement
□Proliferative retinopathy due to diabetes mellitus
□Pseudoezfoliation glaucoma
□Retinal Tear RT__ LT__
□Strabismus
□Tear film insuffcoency
□Vitreous Floaters RT__ LT__
□Wears glasses
□Other
□None

Ocular Surgery

□Corneal Transplant RT__ LT__
□Descemet's strip endothelial keratopla
□Cataract extraction RT__ LT__
□Drainage of anterior chamber of eye
□ Trabeculoplasty
□Opotorefractive keratectomy
□Repair of Blepharoptosis
□Repair of eyelid
□Strabismus surgery
□Trabeculectomy
□Punctal Plugs
□Intravitreal injection
□Situ Keratomileusis
□Laser iridotomy
□Therapy for retinal lesion
□YAG laser
□Other

OCULAR MEDICATIONS

Presciption Drops: _____

□None

Over the counter (OTC) Drops: _____

□None

Other Medications: _____

□None

Prescription Pills or Injections: _____

□None

OTC pills/Vitamins, etc: _____

□None

Allergies to Medications:

□None

Social History

Do you Smoke □YES □NO
packs per day _____
Do you drink Acohol □YES □NO

Started smoking _____
Quit smoking _____
per drink per day _____

Additional Information

□Drive in the Daytime □Drive at Nighttime
□Not sexually active
□Sexually active with one partner
□Sexually active with more than one partner
□Same sex partner
□Drug Use
□IV Drug use

Men-65 yrs or older: How many times in the past year have you had 5 or more drinks in a day _____
Women-65 yrs or older: How may times in the past year have you had 4 or more drinks in a day _____

How oftern do you exercise? _____
What is your caffeine use? _____
Occupation and Workplace _____ _____

Family History

(only first degree relatives, Mother, Father, Sister, Brother, Daughter, Son)

Blindness _____
Cancer _____
Cataracts _____
Diabetes _____
Glaucoma _____
Heart Disease _____
Hypertension _____
Macular Degeneration _____
Migraine _____
Retinal Detachement _____
Strabismus _____
Stroke _____
Other _____

Alerts

□Allergy to adhesive
□Allergy to lidocaine
□Artificial heart valve
□Artificial joints w/in past two years
□Blood thinners
□Defibrillator
□Flomax use
□MRSA
□Foreign Travel
□Narrow angles
□Pacemaker
□Premedication prior to procedures
□Rapid heart beat with Epinephrine
□Pregnant or planning a pregnancy
□Pseudoexfoliation syndrome
□Steroid responder

Review of Systems

□Poor Vision
□Eye Pain
□Tearing
□Redness
□Jaw Pain
□Scalp Tenderness
□Amaurosis Fugax
□Loss of vision
□Fever
□Chills
□Weight Loss
□Stuffy Nose
□Ear Ache
□Cough
□Dry Mouth
□Elevated Blood Pressure
□Rapid Heart Beat
□Congestion
□Wheezing
□Shortness of Breath
□Upset Stomach
□Diarrhea
□Constipation
□Burning on urination
□Urinary Frequency
□Incontinence
□Joint Pain
□Stiffness
□Arthritis
□Rash
□Changing Moles
□Headache
□Seizure
□Stroke
□Paralysis
□Anxiety
□Depression
□Insomnia
□Uncontrolled Blood Sugar
□Thyroid abnormalities
□Bleeding
□Anemia
□Allergies
□Hay Fever
□Hives

Other _____ _____

If you are 65 years of age or older, please answer these questions.

Vaccination Status

Have you received a pneumonia vaccination? □Yes □No

Advance Care Planning

Do you have a health care proxy if you are unable to make medical decisions? □Yes □No

If yes, Name _____ Phone Number _____

Do you have a living will? □Yes □No

Which statement reflects your advance care wishes?

□Do Not Intubate - I do not wish to have a breathing tube.

□Do Not Resucitate - I do not wish to have CPR or an automated external defibrillator.

□Full Cardiopulmonary Resuscitation - All efforts should be made.

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone # _____

Address: _____

Completed by: □Patient Other: _____ Relationship to Patient_____

I attest that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE OF INFORMATION

PATIENT INFORMATION:

Name _____ Date of Birth _____

Address _____ Apt# _____

City, State, Zip _____

Cary Eye Center, PLLC. is authorized to release protected health information pertaining to the above named patient to the person(s) or company listed below.

Description of information to be released (please initial each item that you are authorizing to be released)

_____All information

_____Financial/Billing information

_____Medical information including results from any diagnostic tests

_____Other information as described_____

_____

Person(s) or Company to Receive Information (spouse, children, partner)

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Patients Rights

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and my no longer be protected by federal or state law. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification. I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

_____

Signature of Patient or Personal Representative Relationship Date

FOR OFFICE USE ONLY

We were unable to obtain the acknowledgment for the following reasons:

_____An emergency existed and signature not possible

_____Unable to communicate with patient

_____Patient refused to sign

_____ Other _____

Notice of Privacy Practices

Cary Eye Center, PLLC.

Effective Date: December 15, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY NE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOT HIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

If you have further questions, please contact our Privacy Officer:
Janet Graham
100 Parkway Office Court
Suite 200
Cary, NC 27518

1. **Purpose** – We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at Cary Eye Center, PLLC (the "Practice") in order to provide you with quality care and to comply with certain legal requirements.

   This Notice of Privacy Practices (the "Notice") describes how we may use and disclose your PHI to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information that may identify you that relates to your past, present, or future physical or mental health or condition and related health care services.

   We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the Notice of Privacy Practices currently in effect. If you have any questions about this Notice, please ask to speak with our Privacy Officer.

2. **Written Acknowledgement** – You will be asked to sign a written statement acknowledging that you have been offered an opportunity to review this Notice and to receive a copy upon request. The acknowledgement only serves to create a record that you have been offered a copy of this Notice for review.

3. **Changes to this Notice** – We may change the terms of our Notice at any time. The new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised copy, you may call our office and request that a revised copy be sent to you in the mail, or you may ask for one at the time of your next appointment.

4. **How We May Use and Disclose Your Protected Health Information** – You PHI may be used and disclosed without your prior authorization by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Practice, and any other use required by law. The following categories describe the different ways that the Practice may use and disclose your PHI without your prior authorization. Examples of these situations are also provided. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that may be made by the Practice. Other uses and disclosures of you PHI that are not listed or described in this Notice will be made only with your prior written authorization. You may revoke this authorization at any time in writing, but it will not apply to any actions we have already taken.

   Uses and Disclosure That May Be Made Without Your Prior Written Authorization:

   - **Treatment:** Your PHI may be used and disclosed by us for the purpose of providing medical treatment to you or for another health care providing medical treatment to you. For example, a nurse obtains treatment information about you and documents it in your medical record, and the physician has access to that information. If you require an x-ray to be taken, the x-ray technician also has access to your PHI. In addition, your PHI may be provided to a physician to whom you have been referred or are otherwise seeing to ensure that the physician has the necessary information to diagnose or treat you. This may also include your primary care physician, physician who referred you to our practice, or pharmacy employees involved in filling or managing your prescriptions.
   - **Payment:** Your PHI may be used and disclosed by us to obtain payment for your health care bills or to assist another health care provider in obtaining payment for its health care bills. For example, we may submit requests for payment to your health insurance company for the medical services that you received. We may also disclosed your PHI as required by your health insurance plan before it approves or pays for the health care services we recommend for you.
   - **Health Care Operations:** You PHI may be used and disclosed by us to support our daily operations. These health care operation activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school student's that see patients at our office. We may also use your PHI to determine how we can improve the services and care the Practice offers.
   - **Health Care Operations of Other Health Care Providers:** We may also use or disclose your PHI to assist other health care providers treating you with its quality improvement activities, evaluation of the health care professionals or for fraud and abuse detection or compliance. For example, we may disclose your PHI to another practice to assist in its efforts with complying with all rules related to operating a medical practice.
   - **Appointment Reminders:** We may use or disclose your PHI to contact you to remind you of your appointment by mail, email, text or by telephone. Our message will include the name of the Practice or the name of the treating physician as well as the date and time of your appointment or a reminder that an appointment needs to be rescheduled.
   - **Treatment Alternatives:** We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may contact several home health agencies or physical therapy providers to discuss the services they provide when we have a patient who needs these services.
   - **To Our Business Associates:** We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the Practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written agreement with that business associate that contains terms that will protect the privacy of your PHI. For example, the Practice may hire a billing company to submit claims to your health care insurer. Your PHI will be disclosed to this billing company, but a written agreement between our office and the billing company will prohibit the billing company from using your PHI in any way other than what we allow.
   - **Emergencies:** We may use or disclose your PHI in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your healthcare provider or another healthcare provider in our Practice is required by law to treat you and the healthcare provider has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Uses or Disclosure that Require Us to Give you an Opportunity to Object:

- **Others Involved in Your Health Care or Payment for Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly related to that person's involvement in your health care. You will be asked to identify such individuals in writing for our medical records. Failure to provide this written notice may result in family members or others involved in your care being denied access to your information. If this written indication is absent, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your PHI to notify a family member or any other person that is responsible for your care of your location and general health condition.
- **Disaster Relief**: We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or others involved in your health care.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Consent or Object:

- **As Required by Law:** We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or discloser.
- **Public Health Activities:** We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, the disclosure may be made for the purpose of controlling disease, injury or disability. We may disclose your PHI, if directed by the public health authority, to any other government agency that is collaborating with the public health authority.
- **Food and Drug Administration:** We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products to enable product recalls; to make repairs the operating room replacements; or to conduct post marketing surveillance, as required.
- **Communicable Diseases:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Abuse or Neglect:** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence as may be required or permitted by North Carolina and/or federal law.
- **Health Oversight:** We may disclose your PHI to a health agency for activities authorized by law. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs (such as Medicare or Medicaid), other government regulatory programs and civil rights law.
- **Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena or other lawful request.
- **Law Enforcement:** We may disclose your PHI, so long as all legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Your PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocol's to ensure the privacy of your PHI.
- **Criminal Activity or Threats to Health and Safety:** Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your medical information if it is necessary for law enforcement authorities to identify or apprehend and individual.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Sponsors of Group Health Plans:** We may disclose your PHI to the sponsor of a self-funded group health plan, as defined under ERISA. We may also give your employer information on whether you are enrolled in or have unenrolled from a health plan offered by the employer.
- **Workers' Compensation**: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
- **Inmates and Individuals in Police Custody:** If you are an inmate of a correctional facility or in police custody, we may use or disclose your PHI to the correctional institution or a law enforcement official having lawful custody of you or other individual if the use or disclosure of PHI is necessary for providing healthcare to you or for protecting your health and safety or the health and safety of other inmates or correctional officers.
- **Fundraising:** We may contact you to raise funds. We may use and disclose your PHI, including your demographic data, dates of health care provided, the department from which you received the services, the name of the treating physician, outcome information, and health insurance status to a business associate or institutionally related foundation for fundraising purposes with your authorization. You have the right to opt out of reviewing fundraising communications from us, our business associates, and our institutionally related foundations. Each fundraising communication will provide you with a clear opportunity to elect not to receive further fundraising communications.
- **Required Uses and Disclosures:** Under the law, we must make certain disclosures to you as described below and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act and its regulations.

Uses and Disclosures Based Upon Your Written Authorization: Other uses and disclosures of your PHI that are not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the Practice has already taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosure of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) uses and disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not otherwise described in this Notice of Privacy Practices.

5. **Your Rights.** Following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.
   - **You have the right to inspect and copy your PHI.** You may inspect and obtain a copy of your PHI so long as we maintain the PHI. The information may contain medical and billing records and any other records that we use for making decisions about you. As permitted by federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action; and medical information that is subject to law that prohibits access to medical information in certain circumstances. We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to you medical record.
   - **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Except as provided below, we are not required to agree to a restriction that you request. All request for restrictions of your PHI must be made in writing to our Privacy Officer. We are required to agree to a request to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service; however, there may be Medicare, Medicaid, and other exemptions by law that apply.
   - **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request. Please make this request in writing to our Privacy Office.
   - **You may have the right to ask us to amend your PHI.** You may request an amendment of your PHI so long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a disagreement with us, and we may respond with a written rebuttal to your statement and will provide you with a copy. Please contact our Privacy Officer if you have questions about amending your medical record.
   - **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice. It excludes disclosures we may have made directly to you, disclosures pursuant to a valid authorization, for a facility directory, to family members or friends involved in you care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred six (6) years prior to the date of the request. The right to receive this information is subject to certain exceptions, restrictions, and limitations.
   - **You have the right to obtain a paper copy of this Notice from us.** You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.
   - **You have the right to receive notifications of a data breach.** We are required to notify you upon a breach of any unsecured PHI. PHI is "unsecured" if it is not protected by a technology or methodology specified by the Secretary of Health and Human Services. A breech is the acquisition, access, use or disclosure not permitted by law that compromises the security or privacy of the PHI. The notice must be made within sixty (60) days from when we become aware of the breach. However, if we have insufficient contact with you, an alternative method (posting on a website, broadcast media, etc.) may be used.

6. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer who will be happy to assist you. You may file a complaint with us by notifying our Privacy Officer who will be happy to assist you. You may file a complaint with us by notifying our Privacy Officer of your complaint. If you do not wish to file a complaint with us directly, you may contact the Secretary of Health and Human Services. **We will not retaliate against you for filing a complaint.**

7. **Privacy Officer Contact:** If you have any questions about this Notice or require additional information, Please ask a staff member for assistance or contact our Privacy Officer, Cary Eye Center, PLLC, 100 Parkway Office Court, Suite 200, Cary, NC 27518, ATTN: Privacy Officer, Phone: 919-322-1995.

8. **Effective Date:** This Notice became effective on October 27, 2014.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

If you have any questions, please contact our Privacy Officer:

Janet Graham
100 Parkway Office Court, Suite 200
Cary, NC 27518

I hereby acknowledge that I have been given an opportunity to view a copy of the Practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement

□Other (Please Specify)

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Cary Eye Center

100 Parkway Office Court
Suite 200
Cary, NC 27518
919-322-1995

Cary Eye Center is located at 100 Parkway Office Court, Suite #200. Our office complex can be a bit difficult to navigate. Our building number is 100. Suite 200 is on the back side of building 100. The direction in which you are traveling down Cary Parkway will determine which entrance is easiest to enter.

*The main entrance will put you on the front side of building 100. To get around to the back side of building 100, you will have to go through the round-a-bout where the fountain is. Take the 4th exit off the round-a-bout – this puts you in front of building 155 (you will see Blue Ridge Dermatology). Turn right between buildings 155 & 135. Turn right again which will put you on the backside of all buildings. Follow the road all the way around and our office is the last one you come to before getting back onto Cary Parkway.

*If you are traveling down Cary Parkway WEST to EAST and cross over US 1, there is a side entrance that will put you right at our office. After crossing over the highway go straight through a traffic light. Soon after a right turn lane will open up – *this comes up quick* – there is a sign that says Parkway Professional Park, Raleigh Radiology, and UNC Cancer Center (it is difficult to see until you are right on it). Take this entrance and we are ahead on the left.

Our name is on the building and on our front door.
Please do not hesitate to call if you need assistance finding our office.