

Insurance Information: All charges not covered by the insurance carrier will be the responsibility of the patient.

Vision insurance will cover routine services and glasses--benefits only covered once per year (or every 2 years).

Medical insurance MAY cover the examination if there is a medical problem with the eyes.

Vision Insurance: Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Social Security # _____ **This is only necessary if you do not have a card

Medical Insurance:

Primary Insurance Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Secondary Insurance Company _____ Relationship to Insured _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

I attest that the information included on this form is correct to the best of my knowledge

I understand the HIPAA Privacy Policy as stated below and I understand that a copy of the full privacy practices of Kramer Family Vision may be furnished upon request.

Patient Signature: _____ **Date:** _____

Summary of HIPAA NOTICE OF PRIVACY PRACTICES

WE MAY USE YOUR INFORMATION FOR TREATMENT PURPOSES BY:

- Setting up an appointment or confirmation of an appointment already made (including reminder postcards and messages left on an answering machine).
- Testing or examining your eyes; Prescribing glasses, contact lenses, or eye medications (and faxing them to be filled) ; showing you vision therapy or low vision aids .
- Referring you to another doctor or clinic for eye care, surgery, low vision aids, or vision therapy services or getting copies of your health information from another professional.

WE MAY USE YOUR INFORMATION FOR PAYMENT PURPOSES BY:

- Asking about health and vision care plans or other sources of payment.
- Preparing and sending bills or claims.
- Collecting unpaid amounts (ourselves or through a collection agency or attorney).

WE MAY USE YOUR INFORMATION TO MAINTAIN THE HEALTH CARE OPERATIONS OF OUR OFFICE BY:

- Financial or billing audits, Internal quality assurance, Personnel decisions, Participation in managed care plans, Defense of legal matters, Business planning, or Outside storage of records

*We routinely use your health information inside our office for these purposes without any special permission.

*If we need to disclose your health information outside our office for these reasons, we will ask you for special written permission.

USES/DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

We are obligated to release your information in the following circumstances:

- When mandated by state or federal law that certain health information be reported.
- Disclosures to governmental authorities regarding victims of suspected abuse, neglect, or domestic violence.
- 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.
- Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.