

Notice of Privacy Policies for Crossroads Eye Care Associates, Ltd
4160 Washington Rd. McMurray PA 15317

THIS INFORMATION DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, PRINT IT, SIGN IT, AND RETURN IT TO US PRIOR TO YOUR APPOINTMENT. YOU MAY ALSO GIVE IT TO US AT YOUR APPOINTMENT TIME.

Introduction:

At Crossroads Eye Care Associates, Ltd. We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14th, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Crossroads Eye Care Associates, Ltd., a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, 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 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 this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its' accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Crossroads Eye Care Associates, Ltd., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Policies upon request.
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524, for an additional fee as outlined per Act 26 of Pennsylvania State Law.
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Crossroads Eye Care Associates, Ltd. is required to:

Maintain the privacy of your health information,
Provide you with this 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 if we are unable to agree to a requested restriction, and
Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices, and to make the practices' change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedure included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at 724.941.1466, Ext. 110.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights (OCR) , U.S. Department of Health and Human Services. There will be no retaliation for filing a complain with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is -listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Crossroads Eye Care Associates Will Use and Disclose Your Protected Health Information in These Ways

1. **Treatment:** Crossroads Eye Care Associates, Ltd., will use your Protected Health Information to take care of you. For example, you may get lab tests (such as blood tests), and the results may be used to help reach a diagnosis. Crossroads Eye Care Associates, Ltd. might use your Protected Health Information in order to write a prescription for you, or might tell your Protected Health Information to a pharmacy when calling and ordering a prescription for you. Many of the people who work for Crossroads Eye Care Associates, Ltd., including doctors, ophthalmology technicians, surgery schedulers, receptionists and others, may use or tell of your Protected Health Information in order to treat you or to help others in your treatment. There may also be doctors, nurses, and others who do not work for Crossroads Eye Care Associates, Ltd., who take care of you after you come to Crossroads Care Associates, Ltd., who Crossroads Eye Care Associates, Ltd., will give your Protected Health Information to if they need this information to take care of you. Also, Crossroads Eye Care Associates, Ltd. may share your Protected Health Information to others who may help in your care,, such as your spouse, children, or parents. Additionally, we will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

2. **Payment.** Crossroads Eye Care Associates, Ltd. will use and disclose your Protected Health Information in order to bill and receive payment for the services and items you may receive from Crossroads Eye Care Associates, Ltd. For example, Crossroads Eye Care Associates may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and Crossroads Eye Care Associates, Ltd. may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. Crossroads Eye Care Associates, Ltd. also may use and tell your Protected Health Information to obtain payment from third parties that may be responsible for such costs, including family members, insurance companies, HMOs, etc.
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, services rendered, and products provided.
3. **Health Care Operations.** Crossroads Eye Care Associates, Ltd. will use and disclose your Protected Health Information to manage its businesses called “operations”.
For example: Members of our medical staff may use your Protected Health Information to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
4. **Appointment Reminders.** Crossroads Eye Care Associates, Ltd. will use and disclose your Protected Health Information to contact you and remind you of an appointment, via telephone and by forwarding postcards to your home address.
5. **Sign-In Sheets.** Crossroads Eye Care Associates, Ltd. will require you to sign-in at the time of each appointment. Additionally, your name will be called, within the reception area, to alert you of when it is time for you to enter an examination or work-up room.
6. **Treatment Options.** Crossroads Eye Care Associates, Ltd. will use and disclose your Protected Health Information to tell you the different ways you can be treated.
7. **Release of Information to Family/Friends.** Crossroads Eye Care Associates, Ltd. using their best judgment, may share your Protected Health Information with a friend, family member or any other person you identify, who is helping you pay for your health care, or who assists in taking care of you, unless you tell Crossroads Eye Care Associates, Ltd. not to do so.
8. **Business Associates.** There are some services provided in our organization through contacts with business associates. Examples include answering services, transcription services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we’ve asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
9. **Disclosures Required by Law.** Crossroads Eye Care Associates, Ltd. will use and disclose your Protected Health Information when required to do so by federal, state, or local law.
10. **Law Enforcement.** Crossroads Eye Care Associates, Ltd. may disclose Protected Health Information if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations.
 - Concerning a death which might have resulted from criminal conduct.
 - Regarding criminal conduct at Crossroads Eye Care Associates, Ltd. facility.
 - In response to a warrant, summons, court order, subpoena or similar legal process.
 - To identify/locate a suspect, material witness, fugitive or missing person.
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the person responsible).

11. Organ and Tissue Donation. Crossroads Eye Care Associates, Ltd. may tell Protected Health Information to organizations that handle organ eye or tissue donation and transplantation, including organ donation banks, as necessary, to help organ or tissue donation and transplantation if you are an organ donor or potential recipient.
12. Serious Threats to Health or Safety. Crossroads Eye Care Associates, Ltd. may use and disclose your Protected Health Information when necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. Under these circumstances, Crossroads Eye Care Associates, Ltd. will only tell your Protected Health Information to the person or organization able to help prevent the threat.
13. Military. Crossroads Eye Care Associates, Ltd. may disclose your Protected Health Information if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.
14. Education. Crossroads Eye Care Associates, Ltd. may use and disclose your Protected Health Information in the course of training people to become doctors and other types of health care providers.

Patients are to keep the Policy Information of this document (pages 1 – 6).

You are asked to Complete the Following Two Pages (pages 7 & 8), sign and return these 2 pages prior to or on the day of your scheduled appointment.

Crossroads Eye Care Associates, Ltd. 4160 Washington Rd., McMurray PA 15317

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Crossroads Eye Care Associates, Ltd. Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

Additionally, I authorize the physicians, or members of the staff of Crossroads Eye Care Associates, Ltd. to discuss my medical treatment and/or financial charges, related to this treatment with the following individuals.

Emergency Contact Name _____

Relationship _____ Phone _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient Signature: _____ Date: _____

If not signed by patient, please indicate your relationship to patient, (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only

If a patient or patient's representative refuses to sign this Acknowledgement of Receipt of Notice, please document the date and time the notice was presented to patient and sign below.

Present on (date and time): _____

By: (name and title): _____

Acceptance of Financial Responsibility

I request that payment of authorized insurance benefits be made, on my behalf, to Crossroads Eye Care Associates, Ltd., for any and all services furnished to me by Crossroads Eye Care Associates, Ltd. physicians or staff members.

I agree and understand that all services rendered to me by Crossroads Eye Care Associates, Ltd. were necessary for treatment of my medical condition(s) and that I am personally responsible for all charges which my insurance carrier does not pay, including but not limited to co-insurance, co-payments, deductibles and non-covered services.

I agree to make payment in full for all services due, by me personally, within 28 days of receipt of billing.

I understand and agree that this authorization will remain in effect until such time that I request, in writing, termination of this authorization.

Patient Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____