PATIENT REGISTRATION

Name (Last): _____ First: _____ MI: _____ MR#: _____
Internal Use Only

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Month Day Year

Marital Status: ☐ Married ☐ Single ☐ Other

Race: ☐ Caucasian ☐ Black ☐ Hispanic/Latino ☐ Asian ☐ American Indian ☐ Native Hawaiian/Pacific Islander ☐ Other

CONTACT INFORMATION

Address: _____
Street City, State /Province Zip / Postal Code Country

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Employer: _____ Occupation: _____

HEALTHCARE & VISIONCARE PROVIDER INFORMATION

Family Physician: _____ Dr's Phone: _____

Address: _____
Street Suite Number City, State /Province Zip / Postal Code Country

Date of last full Physical Exam: _____

Pharmacy: _____ Pharmacy Phone: _____

Eye Doctor: _____ Dr's Phone: _____

Address: _____
Street Suite Number City, State /Province Zip / Postal Code Country

Date of last Eye Exam: _____

Prior to your procedure, your eyes will be dilated and a full eye examination will be performed. **It is recommended that you have a driver as your vison may be blurry right after a dilated eye exam.**

By signing below you agree that all information given on this form is true to the best of your knowledge.

_____ _____
Signature of Patient or Personal Representative Date

If Personal Representative, please print your name and describe your relationship to the patient: _____

PATIENT MEDICAL HISTORY (1)

CATARACT VISION INSTITUTE

Name (Last): _____ First: _____ MI: _____ MR#: _____

MEDICAL INFORMATION

Medical Allergies:
☐ None ☐ List below:

Current Medications: ☐ None ☐ List below:
(Please bring a list of all Prescription and Non-Prescription Medications and/or medicine bottles)

Check All that Apply:

☐ Arthritis
☐ Diabetes
☐ High Blood Pressure
☐ Tuberculosis (TB)
☐ Pacemaker
☐ Lupus
☐ HIV / AIDS
☐ Depression
☐ Asthma
☐ MRSA Carrier
☐ Healing Problems / Keloid Scars
☐ Autoimmune Disorders
☐ Pregnant / Breastfeeding - or - planning to become pregnant within the next 6 months
☐ Health Care Worker / Patient Care Contact
☐ Other: _____

EYE HISTORY

Past Ocular History:
(State Which Eye)
☐ No Past Eye History

☐ Cataracts _____
☐ Double Vision _____
☐ Strabismus _____
☐ Dry Eyes _____
☐ Glaucoma, you or family_____
☐ Corneal Abrasion _____
☐ Retinal Tear/Detachment_____
☐ Herpes Simplex/Zoster _____
☐ Keratoconus, you or family _____
☐ Amblyopia/Lazy Eye _____
☐ Trauma/Foreign Body/Scar _____
☐ Recurrent Corneal Erosion _____

Past Ocular Surgery:
(State Which Eye)
☐ No Past Eye Surgery

☐ LASIK / PRK_____
☐ RK / AK _____
☐ Corneal Transplant ___
☐ Muscle Surgery _____
☐ Retinal Surgery _____
☐ Other: _
☐ Cataract Surgery _____
☐ Glaucoma Surgery _____

Contact Lens History:
If You Wear Contact Lenses, When Were They Last Worn?
_____

☐ No Contact Lenses
☐ Soft Daily Wear
☐ Soft Overnight Wear
☐ Soft Toric
☐ RGP or Hard lenses
Years Worn: _____

If you have ever had difficulty with Contact Lens wear, please explain:
_____
_____
_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person: _____ Relationship: _____

Phone Number:_____ Cell Phone Number: _____

_____ _____
Signature of Patient or Personal Representative Date

If Personal Representative, please print your name and describe your relationship to the patient: _____

Reviewer's Initials: _____ Date: _____

PATIENT MEDICAL HISTORY (2)

Name (Last): _____ First: _____ MI: _____ MR#: _____

ADDITIONAL MEDICAL INFORMATION

Age: _____ Height: _____ Weight: _____

Have you, or are you currently being treated for any of the following conditions? Please Check Yes/No and Explain.

Circle Any Conditions That Apply:	YES	NO	Explain:
Heart Failure, Stroke, Angina/Chest Pain, Chest Tightness, Fluid in Your Lungs, Blackouts, Seizures	☐	☐	
High Blood Pressure, High Cholesterol, Irregular Heart Beat, Heart Murmur, Mitral Valve, Other (Specify)	☐	☐	
Respiratory Problems, Asthma, Shortness of Breath, Wheezing, Coughing, Sleep Apnea, Emphysema, Other (Specify)	☐	☐	
Blood Disorders, Lymphatic Disorders, Leukemia, Hepatitis, Blood Clots, Excessive Bleeding, Other (Specify)	☐	☐	
Thyroid Problems, Diabetes, Endocrine Disorders, Other (Specify). If you have Diabetes: ☐ Diet Controlled ☐ Pills ☐ Insulin	☐	☐	
Muscle Aches or Problems, Joint Pain, Swollen Joints, Weakness, Arthritis, Jaw or Neck Pain, Other (Specify)	☐	☐	
Allergies, Any Reaction to Anesthetics, Immunologic diseases, Other (Specify)	☐	☐	
Gastrointestinal Problems, Heartburn, Abdominal Pain, Diarrhea, Vomiting, Other (Specify)	☐	☐	
Skin Rashes, Excessive Dryness, Jaundice, Other (Specify)	☐	☐	
Fever, Weight Loss, Thyroid Problems or Kidney Problems	☐	☐	
Depression, Anxiety, Psychiatric Problems, Other (Specify)	☐	☐	

Do you have any other medical problems? Please List:

Do any of the following diseases run in your family? Please circle and note the person's relationship to you.

Glaucoma / Macular Degeneration / Diabetes / Cataracts / High Blood Pressure

_____ _____ _____ _____ _____

ADDITIONAL SOCIAL INFORMATION:

Are you a smoker? ☐ Yes ☐ No If Yes, how much? _____ Number of Years: _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks per week? _____

Do you use any recreational drugs? ☐ Yes ☐ No If Yes, what drugs and how much? _____

_____ _____

Signature of Patient or Personal Representative Date

If Personal Representative, please print your name and describe your relationship to the patient: _____

Reviewer's Initials: _____ Date: _____

PATIENT QUESTIONNAIRE (1)

Name (Last): _____ First: _____ MI: _____ MR#: _____

If it is determined that surgery is appropriate for you, this questionnaire will assist us to provide the best treatment for you.

IT IS IMPORTANT TO UNDERSTAND THAT MANY PATIENTS
STILL NEED GLASSES FOR SOME ACTIVITIES AFTER THEIR SURGERY.

We divide visual needs into these three distances:

Near (10 to 19 inches)	Intermediate (20 inches to 4 feet)	Far (20 feet and beyond)
Fine Print	Television / Personal Electronic Devices	Driving
Phone Book	Computer / Car Dashboard	Road Signs
Maps	Menus / Cooking	Movies
Sewing	Talking with Friends	Golf
Shaving / Polishing Nails	Shopping	Sporting Events
Using a Tape Measure	Playing Cards	Sunrise / Sunset

Which of the above is the most important to you? (Please choose only one.) ☐ Near ☐ Intermediate ☐ Far

If you have to wear glasses for one distance after surgery, which would you choose? ☐ Near ☐ Intermediate ☐ Far

If you have to wear glasses for the other distances after surgery, would that be acceptable to you? ☐ Yes ☐ No

Please circle the number that best indicates your personality:

Easy Going 1 2 3 4 5 6 7 8 9 10 Perfectionist

Have you ever been bothered by any of the following:	YES	NO	COMMENTS
Poor Night Vision?	☐	☐	
Seeing rings or halos around lights?	☐	☐	
Glare caused by headlights or bright sunlight?	☐	☐	
Hazy and/or blurry vision?	☐	☐	
Seeing poorly in dim light?	☐	☐	
Poor color vision?	☐	☐	

Any other vision problems we should know about?

_____ _____

Signature of Patient or Personal Representative Date

If Personal Representative, please print your name and describe your relationship to the patient: _____

Reviewer's Initials: _____ Date: _____

PATIENT QUESTIONNAIRE (2)

Name (Last): _____ First: _____ MI: _____ MR#: _____

Which eye is being evaluated for surgery? ☐ Right Eye ☐ Left Eye ☐ Both Eyes		
Visual Function: Do you have difficulty, even with glasses, with the following activities?	**YES**	**NO**
Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐
Reading a newspaper, book, or magazine?	☐	☐
Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	☐	☐
Recognizing people when they are close to you?	☐	☐
Seeing steps, stairs, or curbs?	☐	☐
Reading traffic signs, street signs, or store signs?	☐	☐
Doing fine handwork such as sewing, knitting, or carpentry?	☐	☐
Writing checks or filling out forms?	☐	☐
Playing card games, board games, or dominoes?	☐	☐
Taking part in sports like tennis, golf, or other activities due to poor vision?	☐	☐
Cooking or working at counter top levels?	☐	☐
Watching television?	☐	☐
Other vision activity problems? (specify)		

DRIVING

1. Do you currently drive a car? ☐ Yes (Continue with the next questions) ☐ No (Proceed to # 4 below)
2. How much difficulty do you have <u>driving during the day</u> because of your vision?
   ☐ No difficulty ☐ A little difficulty ☐ Moderate Difficulty ☐ A great deal of difficulty
3. How much difficulty do you have <u>driving at night</u> because of your vision?
   ☐ No difficulty ☐ A little difficulty ☐ Moderate Difficulty ☐ A great deal of difficulty
4. If you stopped driving, was it because of your vision? ☐ Yes ☐ No
   When did you stop driving?
   ☐ Less than 6 months ago ☐ 6 - 12 months ago ☐ More than 1 year ago ☐ Still Driving

_____ _____

Signature of Patient or Personal Representative Date

If Personal Representative, please print your name and describe your relationship to the patient: _____

Review Signature: _____ Date: _____

PATIENT FINANCIAL AGREEMENT

Name (Last): _____ First: _____ MI: _____ MR#: _____

INSURANCE PROVIDERS

Social Security Number: _____ Medicare Number: _____

Employer: _____

#1 Insurance Co. Name: _____ This is my: ☐ Primary ☐ Secondary Carrier

Insurance Co Address (on back of card): _____
Street / PO Box, City, State Zip Code

Subscriber's Name: _____ Subscriber's Birth Date: _____

Group Number: _____ Policy Number: _____

#2 Insurance Co. Name: _____ This is my: ☐ Primary ☐ Secondary Carrier

Insurance Co Address (on back of card): _____
Street / PO Box, City, State Zip Code

Subscriber's Name: _____ Subscriber's Birth Date: _____

Group Number: _____ Policy Number: _____

CONSENT FOR TREATMENT INVOLVEMENT

Please list family members or friends with whom we may discuss your treatment and medical decisions or payment for your care. ☐ No one ☐ Yes. list name and relationship below:

_____ _____

_____ _____

RESPONSIBLE PARTY FOR PAYMENT IF OTHER THAN YOURSELF

Name: _____ Phone Number: _____

Address: _____
Street City, State Zip Code

Relationship: ☐ Spouse ☐ Dependent ☐ Other _____

AUTHORIZATION OF BENEFITS

I understand that the responsible party listed above or I am financially responsible to the provider for charges not covered by this authorization and In the event of failure to pay these charges, will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.

I consent to the release of my medical information for payment purposes to health insurers or third party payers. I hereby authorize payment directly to the provider for insurance benefits otherwise payable to me, but not to exceed the balance due of the provider's regular charge. CVI is providing administrative services on behalf of the physician. CVI is not a medical provider. I understand that my insurance claims will be submitted under the physician's practice name:

_____

Patient Signature: _____ Date: _____

Personal Representative, please print your name and describe your relationship to the patient: _____

On the day of your exam, please bring your current insurance cards and a picture, government-issued ID card.

CATARACT VISION INSTITUTE

Vision Correction Questionnaire

1. I primarily wear: ___ Glasses ___Soft Contact Lenses ___ Hard/Rigid Gas Permeable Lenses

2. Do you wear reading glasses over your contact lenses, or take your glasses off to read? YES / NO

3. Has your prescription changed significantly every year? YES / NO

4. Do you have prism in your glasses? YES / NO

5. Have you ever been diagnosed with dry eye disease? YES / NO

6. Have you had fluctuation in your vision? YES / NO

7. Have you had contact lens discomfort? (If you wear contacts) YES / NO

8. Do you have light sensitivity? YES / NO

9. Do you have the feeling of sand or grit in your eyes? YES / NO

10. Are you currently experiencing any of the following symptoms?
    a. watery eyes c. burning e. eyes feeling tired
    b. redness d. itching
11. Do you use moisture drops? YES / NO

Please check all that apply to you. This applies while wearing your glasses or contacts. If you do not wear correction then please still check all that apply to you as well.

__ Difficulty reading small print
__ I have to use reading glasses if I want to see my computer or to read
__I have difficulty seeing my television clearly
__I do not like to drive at night for the following reason(s)
    __ I don't see well enough to read road signs
    __ I don't see street signs because of the street light glare
    __ I have difficulty with the glare from oncoming headlights or bright sunlight
__ I have difficulty seeing the golf ball
__ I have difficulty doing craft work like I once did
__ I don't participate in sports as much because I don't see as well
__ I have difficulty reading the label on my pill bottles
__ I have difficulty seeing my Bingo cards

Expectation Profile

1. __ I dislike being dependent on glasses for clear vision

   __ I don't mind wearing glasses or contact lenses for most activities

   __ I like wearing glasses and would feel uncomfortable without them

2. __ I was never a good contact lens wearer/candidate

3. __ My overall appearance is improved without glasses

   __ I like the way I look in glasses

4. __ Having good vision without corrective lenses is more important than having great vision with corrective lenses

   __ I am a perfectionist and little irregularities bother me

5. __ I would be happy if my vision was greatly improved, even if I had to wear corrective lenses some of the time

   __ I expect to end up with vision that is as good as my contact or glasses after my procedure but I would feel that vision almost as good would still be successful

   __ I would be very upset if I did not end up with perfect vision after my procedure and would probably consider the entire experience a failure

6. __ I usually adjust well to change

   __ I am somewhat accepting of change

   __ I don't accept changes easily

7. __ I am a fairly easy going person

   __ I try not to let things bother me

   __ I get upset or stressed out easily when things don't seem to happen in just the way I had planned or expected

8. __ I understand that 5% to 10% of patients will require a additional treatment after their procedure

   __ If I need more correction after my procedure, I would be devastated

Profile Information

1. Activities I enjoy

__ Jogging/Running	__ Tennis	__ Swimming
__ Biking	__ Golfing	__ Boating
__ Hiking	__ Skiing	__ Other _____
__ Going to the gym	__ Scuba Diving	
__ Traveling	__ Basketball	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF CATARACT VISION INSTITUTE, LLC ("CVI")

I have received CVI's "Notice of Privacy Practices" (Privacy Notice). CVI has further explained my right to obtain a copy of the Privacy Notice prior to signing this Acknowledgment and Consent and has encouraged me to read the Privacy Notice carefully prior to my signing. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI"). CVI explained to me that the Privacy Notice would be available to me in the future at my request.

CVI has also explained that the **Notice of Privacy Practices** describes in more detail how health information may be used and disclosed. I understand that CVI reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.

I further understand and consent to the following appointment reminders that may be used by CVI: (a) a postcard mailed to me at the address provided by me and (b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

I further understand that I have a right to request that CVI restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, CVI is not required to agree to any restrictions that I have requested. If CVI agrees to a requested restriction, then the restriction is binding on CVI.

I further understand CVI maintains a record of the health care services that it provides to me. I understand I may request a copy of records pertaining to my care and receive more information by contacting CVI's Privacy Officer. CVI will not disclose my record to others unless I direct CVI to do so or unless the law authorizes or compels CVI to do so.

By my signature below I acknowledge <u>receipt</u> of CVI's Notice of Privacy Practices.

_____ _____

Printed Name of Individual Signature of Individual

_____ _____

Signature of Legal Representative Relationship (e.g., Guardian, Parent if a minor)

Date Signed _____/_____/_____ Witness: _____

Inability To Acknowledge Receipt of Notice of Privacy Practices

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Patient refuses to sign

Other (specify)

Signature of Representative:
Date:

NOTICE OF PRIVACY PRACTICES
OF CATARACT VISION INSTITUTE, LLC

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.

Purpose of this Notice

We are required by law to maintain the privacy of your protected health information ("PHI"), provide you with notice of our legal duties and privacy practices with respect to such protected health information, and to notify you in the event of a breach of your unsecured PHI. This Notice applies to all records of the health care and services you receive at Cataract Vision Institute, LLC ("CVI," we" or "us"). This Notice will tell you about the ways in which we may use and disclose your PHI. This Notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI.

Acknowledgment of Receipt of This Notice

You will be asked to provide a signed Acknowledgment of Receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. The delivery of your services will in no way depend upon your signed Acknowledgment. If you decline to sign an Acknowledgment, we will continue to provide your services. We will also use and disclose your PHI for treatment, payment and health care operations, when necessary.

Who Will Follow this Notice

This Notice describes CVI's privacy practices, as well as the privacy practices of:

- any health care professional authorized to enter information into your CVI medical record;
- all departments, sections and units of CVI; and
- all employees, staff, and other CVI personnel.

CVI's Commitment

We are required by law to:

- make sure that your PHI is kept private;
- give you this Notice of our legal duties and privacy practices with respect to your PHI;
- follow the terms of this Notice as long as it is currently in effect. If we revise this Notice, we will follow the terms of the revised Notice currently in effect;
- train our personnel concerning privacy and confidentiality; and
- mitigate (lessen the harm of) any breach of privacy/confidentiality.

Understanding Your Health Record

Each time you visit CVI, a record of your visit is made. Typically, this record contains your diagnoses, examination and test results, treatment, and a plan for care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care, treatment and any follow up care you may need;
- means of communication among the 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;
- tool in educating heath professionals;
- source of information for medical research;

- source of information for public health officials charged with improving the health of the nation;
- source of information for facility planning and marketing; and
- tool which can be used to assess and improve the care rendered and the results achieved.

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.

How We May Use and Disclose Information about You

Except as may be otherwise prohibited by state or federal law, the following categories (listed in bold-face print, below) describe different ways that we use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information fall within the categories below.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you at CVI or provide you with medical treatment or services. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. Different departments of CVI also may share your PHI in order to coordinate the different services that you need. We also may disclose your PHI to health care providers outside CVI who may be involved in your medical care such as physicians who will provide follow-up care.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at CVI may be billed to (and payment may be collected from) a third party. For example, we may need to give your health plan information about the surgery you received at CVI so your health plan will pay us or reimburse you for the surgery. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We are permitted to use and disclose your PHI for health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, employee review and development activities, review and audit activities, management and general administrative activities. These uses and disclosures are necessary to run CVI and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We also may disclose information to faculty physicians, technicians and CVI personnel to conduct training programs. We also may combine certain PHI about several CVI patients as part of a study to determine what additional services CVI should offer, what services are not needed, and whether certain new treatments are effective. We also may remove all information that identifies you from a set of PHI so that others may use that information to study health care and health care delivery without learning who the specific patients are.

To Business Associates for Treatment, Payment and Health Care Operations. We are permitted to disclose your PHI to third party business associates in order to carry out treatment, payment or health care operations. For example, we may disclose your PHI to a company we hire to help us obtain payment for the health care services we provide. Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

Communication with Family, Caregivers, and Close Friends. We may release your PHI to a family member, other relative, close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if: (1) we obtain your written agreement or provide you with the opportunity to object to the disclosure and you do not object; or (2) we reasonably believe that you do not object to the disclosure.

If you are not present for or unavailable prior to a disclosure (i.e., when we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information under such circumstances, we would disclose only information that is directly relevant to the person's involvement with your care.

Marketing. We may use or disclose your health information, as necessary, to provide you with recommendations for alternative treatments, therapies, health care providers or care settings. The definition of marketing under HIPAA excludes communications with individuals about participating providers and plans in a network, or about a patient's treatment, case management or care coordination.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at CVI.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Special Situations

As Required By Law. We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities. We may disclose your PHI for public health activities. For example, public health activities generally include:

- reporting reactions to medications or problems with products; or
- notifying patients of recalls of products they may be using.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a subpoena, discovery request, or any other court or administrative order.

Law Enforcement. We may release PHI if asked to do so by police or other law enforcement officials:

- in response to a court order, subpoena, warrant, summons or similar process; or
- about criminal conduct we believed occurred on CVI's premises.

Research. Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the outcomes of surgeries of all patients who received treatment from a particular laser to those who received treatment from another laser. Most research projects, however, are subject to a special approval process. This process requires an evaluation of the proposed research project and its use of PHI, and balances these research needs with our patients' need for privacy. Before we use or disclose PHI for research, the project will have been approved through this special approval process. However, this special approval process is not required when we allow researchers who are preparing a research project to look at information about patients with specific medical needs, so long as the PHI they review does not leave CVI.

Armed Forces and Foreign Military Personnel. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

When Your Authorization is Required

Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with your written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

You may obtain a paper authorization form by contacting:

Cataract Vision Institute
1555 Palm Beach Lakes Blvd., Suite 600
West Palm Beach, FL 33401

Your Rights

You have the following rights regarding the PHI we maintain about you.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree with your request. CVI will notify you in writing whether we agree or do not agree with your request.

In your written request, you must tell us: (1) what information you want to limit; (2) whether you want to limit CVI's use and/or disclosure of the information; (3) to whom you want the limits to apply (for example, disclosures to your spouse); and (4) your contact address.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Usually, this includes medical and billing records. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect or receive a copy in certain very limited circumstances as defined by law.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for CVI. Your written request must include a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the PHI kept by or for CVI; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is accurate and complete. CVI will notify you in writing whether we agree or do not agree with your amendment request. If we deny your request for an amendment, we will notify you how you may file a complaint with CVI or the Department of Health and Human Services.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. The accounting (or list) of disclosures will include: (1) the date of the disclosure; (2) the name of the entity or person who received the PHI and, if known, the address; (3) a brief description of the PHI disclosed; and (4) a brief statement of the purpose of the disclosure. Your request must state a time period not longer than six (6) years. The first list you request within a twelve (12) month period will be free of charge. For

additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Obtain a Paper Copy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

Contact information for these rights. Any requests related to these rights should be directed to:

Cataract Vision Institute
1555 Palm Beach Lakes Blvd., Suite 600
West Palm Beach, FL 33401

Changes to this Notice

We reserve the right to change the terms of the Notice at any time. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. If we change the terms of our privacy Notice, we will post a copy of the current Notice at each CVI location and on CVI's web site. This Notice contains its effective date in the lower right-hand corner. In addition, each time you visit an CVI location you may request a copy of the current Notice in effect.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact CVI's chief privacy officer at (561) 965-9110.

If you believe your privacy rights have been violated, you can file a complaint with CVI's chief Privacy Officer at (561) 965-9110 or in writing to:

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

There will be no retaliation for filing a complaint.

Effective Date

This Notice is effective as of January 1, 2016.