East Highland Family Optometry

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Office: (909) 862-2100 Fax: (909) 862-8831

STATEMENT OF PRIVACY PRACTICES

Our office is committed to protecting the privacy rights of our patients and the confidential information entrusted to us. The dedication of each employee to ensure that your health information is never compromised is of paramount importance in our practice. We amend our privacy practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of California. This includes issues relating to your treatment, payment and our health care procedures. Unless you object, we may share relevant information about you with family members or friends who are helping you with your eye care. Your personal health information will never be otherwise given to anyone without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic system are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality eye care, implement payment activities, conduct normal health practice procedures and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information, and to request a list of instances in which we, or our business associates, have disclosed your protected information. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your health information.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth Date _____

Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I/WE hereby authorize the practice to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Worker's Compensation.

CONSENT FOR TREATMENT: I/WE hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. **If for any reason my insurance denies the claim, I will be responsible for the usual and customary charges that my insurance does not pay for.**

We thank you for completing this form

Richard Kamiyama, OD

Signature: _____

Date: _____