



**EYE CARE
INSTITUTE**

A Medical Corporation

Bruce P. Abramson, MS, OD

*Optometry
Contact Lenses*

Robert L. Anderson, MD

Comprehensive Ophthalmology

Gary P. Barth, MD

*Comprehensive Ophthalmology
Cornea/External Diseases
Laser Vision Correction*

Dan R. Lightfoot, MD

Comprehensive Ophthalmology

Nina Ni, MD

*Comprehensive Ophthalmology
Cornea/External Diseases
Laser Vision Correction*

Daniel G. Rich, MD

*Comprehensive Ophthalmology
Laser Vision Correction*

Kalane J. Wong, MD

Comprehensive Ophthalmology

Lillian Yang, MD

Comprehensive Ophthalmology

Robert C. Kersten, MD, FACS

*Consultant; Ophthalmic Plastic
and Cosmetic Surgery
Department of Ophthalmology, UCSF*

1017 Second Street
Santa Rosa, California 95404
P: (707) 546-9800
F: (707) 546-4112

720 Fourth Street
Santa Rosa, California 95404
P: (707) 575-3800
F: (707) 528-4967

1383 N. McDowell Blvd., Suite 100
Petaluma, California 94954
P: (707) 763-6400
F: (707) 763-6266

www.see-eci.com

Welcome to Eye Care Institute

Your appointment with Doctor _____ is on
M / T / W / Th / F _____. Please
report to the reception desk at _____ am/pm for your
_____ am/pm appointment. This additional time is
needed to prepare your medical record prior to your appointment and
review the information you have provided us.

The enclosed **patient information form** will assist us in the
processing of your insurance claim form(s). The **medical history
form** will provide your physician with valuable information about your
condition. Completing these forms prior to your appointment will
facilitate your time with us. Please answer briefly. **After completing
these forms please bring them with you to your appointment.**
You may also fax the forms to 707-546-4112.

In order to process your insurance billing, ***we must make a copy of
your insurance card(s). Please bring your insurance card(s) to
your appointment or mail a copy in advance (front & back).***
Insurance co-payments are payable at the time of your visit.

If you wear glasses, please bring them with you to your appointment.
If you wear contact lenses, please bring your prescription. If you have
an extensive list of medications please attach this list to your
paperwork with dosage and frequency of each medication taken.

Patients under the age of 18 must be accompanied to their initial
exam by a parent or guardian.

PARKING: Our 2nd Street and Petaluma offices have on-site parking.
The 4th Street office has a parking lot located behind Barnes & Noble
in designated parking spaces along the wall behind our office. There
is also garage parking on 3rd and D Street and various street parking
downtown.

Thank you for your assistance. Please feel free to call me if you have
any questions.

Appointment Scheduler

What to Expect From Your Eye Exam at Eye Care Institute

Your visit to our office may be a comprehensive eye evaluation that might take up to one and a half hours. Your visit may take longer if you need specialized testing or have complex eye problems. Please make sure to allow time for your appointment.

Your evaluation will begin with a medical history that will include any previous ophthalmic history. Please bring your current glasses and any pertinent contact lens information if you wear lenses.

To determine your best vision at distance and near, your visual acuity will be tested using a standardized eye chart.

A refraction, which checks the need for a glasses prescription, will be performed to determine your best possible vision, and may be necessary regardless of whether you plan on getting glasses or contact lenses. There is a \$45.00 charge for a refraction. There is a \$35.00 charge for a contact lens evaluation should you request a contact lens prescription. These charges may not be covered by your health insurance plan and payment will be required at the time of service.

Your eye muscle coordination may be tested to see if the light is being appropriately transmitted to your brain.

A slit lamp microscope examination will be performed to look at health of the front of the eye, which includes your cornea.

Intraocular pressure will be checked to see if your eye pressures are at a normal level.

All new exams normally include a dilated eye exam of both eyes. This important part of the exam will allow the doctor to look at the inside and back of the eyes and check the health of your lens, retina and optic nerve. You may want to bring a driver with you as some people find it difficult to drive after being dilated. Sun glasses should be worn after dilation.

Other tests may also be performed on an as needed basis, depending on what the preceding parts of your examination have revealed. These include formal visual field testing, photography, high resolution scans of the back of the eye, pachymetry to check your corneal thickness and ophthalmic ultrasound.

After the examination(s), your doctor will discuss the results of the exam with you and answer any questions you may have.

Eye Care Institute has an optical shop at each of its locations to take care of your optical needs. We are in-network providers for VSP (Vision Service Plan) and MES (Medical Eye Services). If you have coverage with either of these two plans please bring your insurance card with you. If you do not have an I.D. card for the plan come prepared with the primary members name, date of birth, last four digits of their social security number and employer. This will help us confirm eligibility and obtain authorization for any services provided. **Please add an additional one half hour to your stay at ECI when purchasing new eyewear following your exam.**



**EYE CARE INSTITUTE
(ECI)**

PATIENT DEMOGRAPHIC (please print)

☐ New Patient ☐ Return Patient ☐ Update | Account #: _____

Patient Name _____ E-mail _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Method of Notification: ☐ Patient Portal ☐ Cell Phone ☐ Home Phone ☐ Mail ☐ Other _____

Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W

Social Security # _____ Drivers License # _____ Exp. Date _____

Patient's Employer _____ Occupation _____

Is Today's Visit Work Related? ☐ Yes ☐ No If Yes, Date of Injury _____

Emergency Contact _____ Relationship _____ Phone _____

IF PATIENT IS A MINOR

Father's Name _____ Employer _____

Work Phone _____ Cell Phone _____ Social Security # _____

Mother's Name _____ Employer _____

Work Phone _____ Cell Phone _____ Social Security # _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

☐ HMO ☐ PPO Co-Pay _____ Deductible _____ ☐ HMO ☐ PPO Co-Pay _____ Deductible _____

Name of Plan: ☐ Meritage ☐ Sutter Other _____ Name of Plan: ☐ Meritage ☐ Sutter Other _____

Primary Care Physician _____ Primary Care Physician _____

Subscriber's Name _____ Subscriber's Name _____

ID # _____ Group # _____ ID # _____ Group # _____

Birthdate _____ Social Sec. # _____ Birthdate _____ Social Sec. # _____

Subscriber's Relationship to Patient _____ Subscriber's Relationship to Patient _____

Subscriber's Employer _____ Subscriber's Employer _____

Do you have a 3rd insurance? Insurance Co. _____ Subscriber _____

Do you have a vision plan? Insurance Co. _____ Subscriber _____ Social Security # _____

PERSONAL DEMOGRAPHIC

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other _____ ☐ Decline to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Other _____

HOW DID YOU HEAR ABOUT US?

☐ My Primary Physician ☐ Family/Friend ☐ ECI Website ☐ Internet ☐ Advertisement ☐ My Optometrist ☐ Social Media

☐ Other _____ Specifically, who or what was the source? _____

AUTHORIZATION FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I HEREBY AUTHORIZE EXAMINATION AND TREATMENT OF THE PATIENT NAMED ABOVE. I HEREBY AUTHORIZE THE DIRECT PAYMENT TO ECI OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO, OR ON BEHALF OF, THE PATIENT FOR ANY MEDICAL REASON AND/OR SURGICAL EXPENSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES. I HEREBY AUTHORIZE ECI TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION ACQUIRED IN THE COURSE OF MY CARE TO ALLOW THEM TO PROCESS ANY CLAIMS FOR MEDICAL AND/OR SURGICAL SERVICES.

Responsible Party Signature _____

Date _____

Responsible Party Name (Please Print) _____



Date _____

Kristin Chapman, M.D. | Nina Ni, M.D.

|Sex:

Are you *currently* experiencing problems with:

Y	N	If yes, please explain in the space provided.	Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Fever, chills, night sweats, weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ears, nose, mouth throat	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint, or muscle problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic problems
<input type="checkbox"/>	<input type="checkbox"/>	Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood or lymphatic problems
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or immunologic problems
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary problems	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine problems, such as thyroid disease

Past Medical History:			Past Surgical History:		
Y	N	In the past have you had significant medical problems?	Y	N	Any past major surgeries? Please list
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, if yes, how long?			
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease			
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease			
<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis			
<input type="checkbox"/>	<input type="checkbox"/>	Other significant diseases?			

Primary Care Physician: <i>(First and Last Name)</i>	Current/Past Profession:
Pharmacy:	
Pharmacy Location:	

Please list your current medicines:	Dosage:	For Office Use Only: (<i>Procedures / PO Hx</i>)
List all Drug Allergies:		

Name: _____

Account Number: _____

Eye Care Institute Financial Policy

The physicians and staff of Eye Care Institute (ECI) are committed to providing you with the best possible health care. The following is a statement of the ECI financial policy.

- Patients must complete all information forms prior to seeing the physician. A copy of your insurance card(s) and your ID will be made for your chart
- By law, we must collect your insurance copayment at the time of service. Be prepared to pay your copay at each visit and to pay for any services that will be applied towards your deductible at the time of service
- For uninsured patients, payment is expected at the time of service, unless other financial arrangements have been made prior to your visit

Health Coverage and Insurance

As a courtesy, we must submit insurance claims for insured patients. To insure accurate claims processing, please provide your complete health plan or insurance and I.D. card. Your health plan, insurance company or Medicare may not cover some or all of the services provided. I understand that it is my responsibility to ensure that ECI is a participating provider for my health insurance network. Out of network services may be assessed a higher deductible, co-pay or co-insurance. You will be financially responsible for any services or balances due that are not covered by your health insurance. ECI accepts no responsibility for any referrals or prescriptions not covered by your plan.

Payment on Balances Due:

Timely payment of your balance is required. Your balance is due upon receipt of your statement. Self-pay accounts are due at the time of service, unless other financial arrangements are made. If payment is not made at the time of service, and financial arrangements are not made, your account will be considered past due once you leave the office.

If payment is not received, your account will be reviewed for possible outside collection.

If your payment by check is returned, be advised your account will be assessed a \$25.00 returned check fee. The balance due from returned checks are payable by cash, credit card, money order or cashier's check.

Narrative Reports and Forms

Reports and forms completed by physicians are subject to a fee (verify with the office staff the fee charged for each report/form). Payment is expected at the time you drop your form off to be completed.

Cancellations/Missed Appointments

If you are unable to keep your appointment, please give our office at least 24 hours notice. Failure to do so may result in a missed appointment/procedure change (fee is determined on the length of the appointment time scheduled). Insurances does not cover this expense and you are responsible for payment of this fee. Frequent missed appointments and cancellations interrupt the process of your treatment and may result in discharge from our office.

Patient Relations

The physicians and staff of ECI are committed to providing you with the best possible health care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees or your financial responsibility.

Good doctor/patient relations are based on understanding and open communication. Our staff will make every possible effort to clarify any questions or concerns you may have regarding your account balance. If you have any questions concerning your bill, contact our billing service, the Practice Management Resource Group, at 877-443-4995 immediately.

Coordination of Benefits: Vision care plans (such as VSP or MES) only cover routine vision exams along with eyeglasses and contact lenses. Vision care plans can only be used once during a coverage period (usually a year). Medical insurance should be used if you have any eye health problem or systemic health problem that has ocular complications (for example, diabetes, glaucoma or cataracts). Your doctor will determine if these conditions apply to you. Vision care plans do not cover diagnostic testing. If you have an eye condition, ECI will bill the examination to your health insurance and the refraction to the vision care plan. If allowed by your plan we will use "coordination of benefits" to do this properly and to minimize your out of pocket expenses. You will be responsible for any remaining balances due for deductibles, co-pays, co-insurance or non-covered services.

X _____
Signature of Patient or Responsible Party

Date

Patient's Name (Please Print): _____



NOTICE OF PRIVACY PRACTICES

1017 Second Street,
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www.see-eci.com

1383 N. McDowell Blvd., Suite 100,
Petaluma, California 94954
(707) 763-6400 • (707) 763-6266 Fax

Effective Date: July 27, 2016

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign-in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you

designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website: www.see-eci.com

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below:

Privacy and Security Officer:
Nancy Kennedy • 1017 Second Street, Santa Rosa, CA 95404
(707) 546-9800

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310 • TDD: (415) 437-8311 • Fax: (415) 437-8329
e-mail: OCRMail@hhs.gov

The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Eye Care Institute

1017 2nd Street
Santa Rosa, CA 95404

720 4th Street
Santa Rosa, CA 95404

1383 McDowell Blvd #101
Petaluma, CA 95457

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the office, and that I will be offered a copy of any amended Notice of Privacy Practices.

Signature

Date

Print Name

Telephone Number

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____