Advanced Ophthalmology Associates PLC
330 East Fourteen Mile Road, Suite B
Clawson, Michigan 48017
Phone: 248-589-9500
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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is the policy of Advanced Ophthalmology Associates PLC to disclose your Protected Health Information that includes pertinent procedures and diagnosis to the following:

- To provide either medical treatment or services. This may include administrative and clinical office procedures designed to optimize scheduling and coordination between physician, technician, and business office staff. We may share your health information with, but not limited to, referring physicians, clinical, and pathology laboratories, and pharmacies.
- Your health insurance plan for payment of claims for services rendered at Advanced Ophthalmology Associates PLC.
- For teaching. Examples are, but not limited to, interns, associates, and business and clinical employees. The information may be reviewed during the routine processes of certification, audits, licensing, or credentialing.
- As required by federal, state, local, and workers compensation laws.
- In the case of an emergency. For example, for treatment or when it is necessary to prevent a serious and imminent threat to your health and safety or the health and safety of the public or another individual.
- Friends or family whom you identify as helping you with your treatment, medications, or payment. We will ask your permission first.

We believe regular eye exams are very important, therefore, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Also, we will inform you that your glasses or contacts are ready for pickup. These communications may include mailings or phone calls. Messages maybe left on voice mail or answering machines. Normal test results may also be left. If you do not wish to be contacted in this manner please indicate this to our staff.

Advanced Ophthalmology Associates PLC other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time. In addition you have the following rights:

- The right to request restrictions on certain Uses and disclosures.
- The right to receive confidential communications.
- The right to inspect and copy your health information
- The right to amend your health information
- The right to ask for a description of how and where your health information was used by our office for any reason other that treatment, payment, or health care operations.
- The right to request a paper copy of any electronic Notice.

We are required by law to maintain the privacy of your health information and to provide to you and your representative the Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all our patients receive a copy of the revised Notice.

You are entitled to file a complaint with our Privacy Officer if you believe your privacy rights have been compromised. All complaints will be investigated. Please let us know of your concerns or complaints in writing to: Office Manger, Advanced Ophthalmology Associates PLC, 330 East Fourteen Mile Road, Suite B, Clawson, MI 48017

Consent: I authorize and request medical treatment including, but not limited to, administration of anesthetics and analgesics (Note: eye drops and eye medication are considered anesthetics and analgesics) and any treatments or tests, which in the judgement of the physician and her associates or assistants, is deemed necessary. *The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not with the physician. I hereby release my examiner from all responsibility in connection with this examination*.

Financial Agreement: I understand that I am financially responsible for testing services and procedures that may not be covered under my health care plan. I understand that denied insurance claims become my responsibility. I agree to pay for all charges not covered by my insurance company, including deductibles and co-pays at the time of service. I understand that if I am a member of a managed care plan and require a referral for my visit, it is my responsibility to obtain one prior to my visit. I understand that should I not have a referral I am financially responsible for the visit.
As a service to you, Advanced Ophthalmology Associates PLC participates with Medicare, Blue Cross Blue Shield, and many other insurance plans. We will submit claims to your insurance company for the medical services provided to you. Co-pays, deductibles, and non-covered services must be paid at the time of service.

Medicare and many health insurance plans DO NOT COVER the portion of your complete exam called the refraction-which determines your eyeglasses prescription. The charge is $35.00. Please let us know in advance if you do not wish to have a refraction.

I understand and accept the above statements.

Acknowledgement of Notice of Privacy Policy: I hereby acknowledge that I have been made aware of and received/reviewed the notice of Privacy practices of this office. I am aware that I may receive a paper copy of this if I request.

_____ _____
Signature of Patient or Guardian Date

_____
Witness