Privacy, Payment, and Electronic Delivery Policies

Notice of Privacy Policy

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version. A more complete text is available by request in-office.

What is this all about: HIPAA outlines rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Notice of Payment Policy

Please bring your insurance card and identification with you to each visit. We highly recommend you also contact your insurance carrier to understand your benefits and your patient responsibility for any services. As a courtesy, our office will verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Our office will bill your insurance based on the benefit quote. Your claim will process according to your plan and you may receive a bill from us once we receive final payment from your insurance. Your understanding and prompt payment of these bills are much appreciated.

All copayments, deductibles, co-insurances, and non-covered services are due at the time of service. For self-pay patients, we have a discounted fee schedule for vision exams if paid on the date of service. No insurance claims will be filed for discounted services.

Professional fees (exams, refractions, contact lens evaluations, or any services performed by the doctor) are not refundable.

Accounts that are over 90 days old are considered delinquent and will be subject to a late fee penalty of $25 per service. If your account is overdue, you will be responsible for any collection fees and costs. Checks returned for insufficient funds, closed account, or other problems may be subject to a $35 service charge. Past due balance(s) will be due prior to service unless arrangements are made in advance with the billing department.

Medicare and certain other medical insurances consider obtaining eyeglasses as routine vision care and not a covered medical benefit. Therefore, the portion of your exam that determines your prescription (the refraction), is also considered routine and is a non-covered service. In these cases, refraction fees will be collected at the time of service.

Referrals may be necessary per your insurance if you are seeing one of our doctors for medical reasons. Medical reasons may include, but are not limited to: diabetes, dry eyes, glaucoma, floaters/flashes of light, cataracts, macular degeneration, red eyes, and painful eyes. If you require a referral, please contact your primary care provider two (2) weeks before your appointment (unless it is an emergency) to request one. If a referral is not obtained, you will be responsible for any charges. A referral is not a guarantee of payment by your insurance.

Our office cannot release any patient information without the consent of that patient. If you would like the office to release any patient information (including billing information) to another provider or person, please ask the front desk for a Records Release form. **If a patient is 18 or over and would like a parent or other family member to have access to their records and/or billing information, please ask the front desk for a Release of Information form.**

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We ask that you keep your appointment time, and arrive at the required check-in time. No-shows, late arrivals, and cancellations inconvenience not only our providers, but other patients as well. Our office has limited appointment slots that are in high demand. If you are unable to keep your appointment, we require at least 24-hour advance notice. Cancellations, reschedules, and no shows without adequate notice will result in a **$39 fee per patient, per occurrence**.

Notice of Optical and Optical Payment Policy

ALL OPTICAL SALES ARE FINAL: All optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable, and once ordered, become the financial responsibility of the patient. No refunds are given.

Payment: We require full 100% payment at time of order for custom eyewear.

Providing Your Own Frames for Adjustment or Re-lensing: We are happy to adjust your existing frame(s) or manufacture and insert new prescription lenses into your own pre-used frame(s). Although we use utmost care when adjusting and removing/inserting lenses, physical manipulation of the frame(s) may cause them to crack or break, therefore we cannot be responsible for any damages as they are being used at your request. **It is not recommended to adjust or reuse frame(s) that are older than 3 years.** Regardless of condition or age of the frame, this disclosure applies to *any* frame(s) being used at your request. Please be aware that we may outsource lens manufacturing and lens insertion to a third-party lab. If so, our office cannot be held responsible for any damage or loss of patients' own property, whether it be in transit, or otherwise.

Frame Warranty: If your frame(s) break under normal wearing conditions (as determined by our opticians), we will repair or replace them according to manufacturer guidelines from the date of purchase and only if the frame was purchased from Happy Valley Vision Source. There may be a warranty charge for this service. We do not cover loss, theft, or abuse.

Frame and/or Lens Changes: If you change your mind regarding the frame and/or lenses you selected after your custom lenses have been ordered for that frame, you can select a different frame and/or lenses within 60 days under the following conditions:

You will owe the difference in the new and old frame and/or lens price. However, no refund will be given if the new frame is of lesser value.

- There is a minimum $100 fee for the cost of your new custom progressive, bifocal, or trifocal lenses.
- There is a minimum $50 fee for the cost of your new custom single vision lenses.
- Fees for changes may vary depending on your specific insurance plan and the required copays.

Pick-Up Policy: We recommend picking up your glasses in-office so our optician can properly adjust the frames to fit you appropriately. We will notify you upon the arrival of your order using an automated system via telephone, text message, and/or email. Eyewear not claimed within 90 days becomes the property of Happy Valley Vision Source.

Shipping: We may be able to ship your eyewear directly to you for a nominal fee. Our office is not responsible for lost, stolen, or damaged packages.

Third-Party Ophthalmic Lab: Occasionally a lab may deliver eyeglasses that do not meet our quality standards. If so, they are returned for re-processing and the arrival of your new glasses may exceed the original anticipated wait-time. We will make every effort to keep you informed as to the status of your order.

Consent for Electronic Delivery of Spectacle and Contact Lens Prescriptions:

The FTC Eyeglass Rule and Contact Lens Rule requires you receive a copy of your prescription immediately upon completion of a refractive eye exam and/or contact lens exam. To allow immediate access and to conserve paper, prescriptions will be provided via a HIPAA compliant patient portal, but is also available as a printed hardcopy upon request.

By signing below I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I acknowledge that I have read, understood, and agree to the office payment and optical policy above. I also authorize my spectacle and contact lens prescriptions to be provided to me digitally via my patient portal. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name (Printed):_____

Guardian Name (Printed): _____ **Relationship:** _____