McMILLIAN EYE CARE

NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the Clinic. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote Quality Improvement in the Clinic.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:
- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

The Clinic is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit to the Clinic. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

McMillian Eye Care
ATTN: Office Manager
P.O. Box 383
Atoka, TN 38004

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.
The name and address of the person you can contact for further information concerning our privacy practices is:

McMillian Eye Care
ATTN: Office Manager
P.O. Box 383
Atoka, TN 38004

MCMILLIAN EYE CARE CREDIT POLICY

SERVICES:

1. Payment is required on the day of service with the following exceptions:

   A. Special Arrangements have been made with the accounts manager or

   B. The patient has MEDICARE OR MEDICARE/MEDICAID.

      1. MEDICARE DEDUCTIBLE: Medicare requires you to pay a fee EACH YEAR

      2. MEDICARE CO-PAY: Medicare requires you to pay 20% of your approved charges AFTER your deductible has been met.

   C. The patient has commercial insurance, pays all charges for the day co-payments, deductibles and co-insurance, Assigns benefits to the physician and agrees to pay any remaining balance NOT paid by insurance 30 days from the date insurance is filed by our office.

2. ANY BALANCES REMAINING ASTER INSURANCE SHOULD BE PAID IN FULL WITHIN 30 DAYS OF THE DATE OF SERVICE. IF THE PATIENT OR RESPONSIBLE PARTY IS UNABLE TO PAY THE ACCOUNT IN FULL, THEY SHOULD CONTACT OUR ACCOUNTS MANAGER IMMEDIATELY FOR CONVENIENT TERMS. (ANY ACCOUNT BALANCE REMAINING UNPAID AFTER 90 DAYS FROM THE INITIAL BILLING DATE WILL BE SUBJECT TO TRANSFER TO A COLLECTIONS AGENCY. THE PATIENT OR RESPONSIBLE PARTY WILL BE REQUIRED TO PAY ANY EXPENSES INCURRED DURING THIS COLLECTIONS PROCESS.)

3. Patients should also understand that the physician has the right to REFUSE further treatment of clients that reuse to honor their financial responsibilities with the clinic.

4. The responsible party will accept full responsibility if the patient is A minor (under18) or mentally incapacitated.

I HEREBY REQUEST THAT PAYMENT OF THE AUTHORIZED INSURANCE BE MADE TO McMILLIAN EYE CARE. I AUTHORIZE McMILLIAN EYE CARE TO ACT AS MY AGENT TO HELP ME DETERMINE AND OBTAIN BENEFITS FROM MY INSURANCE COMPANY. i AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS. I HAVE RECEIVED A COPY OF THIS CREDIT POLICY AND AGREE TO COMPLY WITH ALL POLICIES. I AGREE TO PAY ALL COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT. CONTACTS: ALL ORDERS MUST BE PAID IN FULL FOR DELIVERY.