Athena Eye Institute
5282 Medical Dr, Suite 610
San Antonio, Tx 78229
Phone: (210) 780-7595
Fax: (210) 519-3172

Athena Eye Institute: Notice of Policies and Procedures

Welcome to Athena Eye Institute! Thank you for choosing us as your healthcare provider. We are honored to have you as a patient and excited to provide you with quality eye care.

Patient Appointments

Our clinic requires preregistration for new patients and there may be forms for you to complete in order to optimize your care. This allows us to verify demographic, medical, and insurance information prior to meeting you for the first time. Our medical staff will review the information and contact you if we need any additional information. Please be sure to arrive 15 minutes prior to your appointment. All copayments, deductibles, and other health insurance responsibility will be due at the time of service.

Medications and Refills

We generally e-prescribe all medications to the pharmacy of your choice to serve you best. Please note that we require any medication refill requests be made at least three business days prior to when they are needed. The online portal is the most efficient way for you to make medication/refill requests.

Cancellation and Rescheduling Policy

If for any reason, you need to cancel or reschedule your appointment, please use the online portal to do so or let our staff know 48 hours in advance. Please note that office visits cancelled with 24 hours of the appointment or a failure to present for your appointment (no-show) incur a $25.00 fee. More than 2 no-show appointments or more than 2 cancellations may lead to termination of the patient-physician relationship or dismissal from the practice.

Medical Records

You must understand and give your consent to retrieve and review your medical history in order to receive the most informed medical advice and care. If you have previously received eye care, testing, imaging, or healthcare with other providers, we may ask you to complete a form to request that that information be shared with our office to provide you with the best care possible. You understand that medical information provided will become part of your medical record. A link to this form is on our website.

Should you wish to transfer care to another physician or have your medical records reviewed by another physician, you will need to complete an authorization to release records form, which needs to be completed in its entirety for us to process your request to transfer protected health information. All balances should be paid before records are transferred.

Consent to Call

Entry of any telephone number constitutes written consent for Practice Entities to send automated, prerecorded, and artificial voice telephone calls to that telephone number. To alter or revoke this consent, please adjust the settings in the online patient portal.

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Notice of Privacy Practices

Your Rights:

- *Get an electronic or paper copy of your medical record.* You can ask to see or get an electronic copy of your medical record and other health information we have about you. Ask us how to do this (best to request through the patient portal). We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- *Ask us to correct your medical record.* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- *Request confidential communications.* You can ask us to contact you in a specific way (for example home or office phone) or send mail to a different address. We will say "yes" to all reasonable requests.
- *Ask us to limit what we use or share.* You can ask us to not share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information (for example, if you are found to have a condition that requires reporting to health authorities).
- *Get a list of those with whom we have shared information.* You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and healthcare operation, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- *Get a copy of this privacy notice.* You can ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- *Choose someone to act for you.* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- *File a complaint if you feel your rights are violated.* You can complain if you feel we have violated your rights by contacting us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Our Uses and Disclosures

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How do we typically use your health information? We typically use or share your health information in the following ways:

- *Treat you.* We can use your health information and share it with other professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition.
- *Run our organization.* We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- *Bill for your services.* We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- *Help with public health and safety issues.* We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse/neglect/domestic violence, or preventing or reducing a serious threat to anyone's health or safety.
- *Do research.* We can use or share your information for health research.
- *Comply with the law.* We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law.
- *Respond to organ and tissue donation requests.* We can share information about you with organ procurement organizations.
- *Work with a medical examiner or funeral director.* We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- *Address workers' compensation, law enforcement, and other government requests.* We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with law enforcement officials, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- *Respond to lawsuits and legal actions.* We can share health information about you in response to a court or administrative order, or in response to a subpoena.

For certain heath information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and the choice to tell us to:

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  - Share your information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
  - Contact you for fundraising efforts
  - If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.
- In these cases, we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- In the case of fundraising, we may contact for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.

Acknowledgement of Receipt of Notice of Privacy Practices

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. In signing this document, you acknowledge that you have received and had the opportunity to review a copy of the Notice of Privacy Practices.

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation

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at the following address: Texas Medical Board Attention: Investigations 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2118, MC263 Austin, TX 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-210-9353. For more information please visit www.tmb.state.tx.us.

Thank you again for choosing Athena Eye Institute! We look forward to helping you see your best!

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Code of Conduct, Financial Policy, and Patient Responsibility

This is a legally binding contract between Athena Eye Institute PLLC and the patient. (The words *we* and *our* refer to Athena Eye Institute PLLC. The words *I, me, my, you*, and *your* all refer to you, the patient.)

Athena Eye Institute, PLLC is committed to caring for the eyes of Texas. Our office and physicians are committed to providing you with the highest quality care at a fair and reasonable cost. To accomplish this goal, we are requesting your help in avoiding unnecessary billing issues that may happen because of incorrect insurance information. The following is a copy of our payment policy. Acknowledgment and understanding of this financial policy must be signed by the patient in order to be seen and receive care.

At each visit, patients are required to present identification and up-to-date insurance cards prior to seeing the physician. Patients are also required to make co-pay and deductible payments at each visit according to terms dictated by their insurance arrangement unless other arrangements are approved by us in writing. Athena Eye Institute PLLC accepts cash, check, and several major credit cards. Please note that if Athena Eye Institute PLLC is given an insurance carrier for which a patient does not have active coverage or if a patient does not have insurance coverage for the visit and any recommended testing, the patient will be responsible for the full financial liability. As a courtesy, Athena Eye Institute PLLC will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and, if applicable, any secondary insurance. Please notify the office as soon as possible of all insurance and address changes. If not notified, the guarantor is responsible for all charges not paid because of insurance coverage changes.

It is the responsibility of the cardholder to know what his or her eligibility and coverage is with his or her insurance carrier. If this is not known, it is suggested that the cardholder verify coverage limits prior to the appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the practice is not participating in your insurance plan, you will be responsible for paying in full at the time of service and have the responsibility of filing your own claim with your insurance company.

It is the patient's responsibility to provide Athena Eye Institute PLLC with accurate and complete information concerning his or her primary and secondary insurance medical benefits. It is also your responsibility to provide us with medical records from other providers, though Athena Eye Institute PLLC can help you request your health information be sent to our office in a health information compliant manner.

For services outside of our practice (like radiology, laboratory, surgery center, hospitals, and other health centers), it is your responsibility to know which facilities are supported by your insurer. If you are not sure, please connect with your insurance carrier prior to scheduling service.

Some insurance plans require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.

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You understand that your signature requests payment be made to pay your claim. Your signature also authorizes the release of medical information necessary to pay your claim. Your signature also authorizes the release of benefits payable and medical information.

Medicare Patient's Signature: By signing below, you authorize payment to be made on your behalf to Athena Eye Institute PLLC for any services provided to you by your provider. You authorize your provider to release to the Health Care Financing Administration and its agents any information needed to determine your benefits.

This document describes your financial and patient responsibilities. You have read and understood Athena Eye Institute's financial policies and you accept responsibility for the payment of any fees associate with your care.

You agree to be financially responsible for payment of Athena Eye Institute's services. Cash, check, and approved credit cards are acceptable forms of payment for these services.

Current insurance cards and identification must be presented at every visit. Athena Eye Institute is not responsible for filing patient insurance claims, but as a courtesy, Athena Eye Institute will do so. You agree to pay the remaining balance after your insurance has paid on your claim immediately upon receipt of statement.

You agree to give Athena Eye Institute PLLC your complete and accurate insurance information for primary and secondary insurance benefits. You understand that if you fail to give complete and accurate information about your insurance benefits this may result in denial of your claim or a delay in payment. You agree to pay Athena Eye Institute PLLC the balance on your account after your insurance claim has been processed.

You agree that if your insurance benefit requires you to provide a referral and if the referral is not in place before your appointment, that you will pay in advance an estimate of charges for your office visit or reschedule your appointment.

Form Fees

FMLA paperwork	$25.00 per set of forms
Physician Letter	$25.00 for a one page letter $10.00 for each additional page
School/Childcare/Institutional Forms	$20.00
Medical Records for Third Party	$30.00 for CD/USB of 500 pages or fewer; $50.00 for over 500 pages $30.00 for first 20 pages of paper then $0.50 for every page thereafter Additional fee for postage/shipping

Cancellation Policy

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You understand that you will be responsible for any missed appointments or any cancelled appointments for which 24 hours' notice was not given. There will be a fee of $25.00 for missed appointments.

You understand there will be a $25.00 fee for any returned checks.

You understand that all services provided to you by Athena Eye Institute PLLC are considered medically necessary. If you fail to have a procedure performed or do not comply with your provider's instructions, it may be against medical advice and may void your insurance benefits. Should this occur, you agree to pay the balance remaining on your account after your insurance has been processed.

You understand that your insurance may or may not agree to the usual, customary, or reasonable charges for your local area. You understand that your benefits may not cover all services or might deny payment for services that have been approved in advance. You agree to pay the balance remaining on your account after insurance has been processed.

If you have a high deductible policy or do not currently have insurance benefits, you agree to pay an estimate of charge for your office visit in advance and understand that other charges may apply.

Athena Eye Institute PLLC has a contract with many insurance companies. Athena Eye Institute PLLC will receive payments from your insurance company for covered services provided by your insurance benefits. You agree to pay the co-payments and deductibles at the time of service. If co-payments are not made at the time of service, you understand that your appointment will be rescheduled.

The practice does not participate in any vision plans. We only bill medical plans for services rendered. Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. Athena Eye Institute may be a participating provider with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether the practice is a provider for both your medical and vision plan. Some charges may be denied by an insurance carrier as investigational, experimental, or not medically necessary and will not be covered by insurance. You understand that your physician may feel that these services are necessary whether or not your insurer carrier deems them payable. In such cases, the patient is obligated to pay for these services in full.

You agree to pay any balance remaining on your account for any reason upon receipt of a statement and you understand that when requested, you must give Athena Eye Institute PLLC your current address and other contact information. You understand that if you fail to pay the balance on your account this may result in Athena Eye Institute PLLC pursuing any collection means possible. Information sent to a collection agency and the past due status may be reported to a credit bureau. If this occurs, it is possible that your treatment by our office may become a matter of public record (confidentiality may be waived). If payments are not made, you may be unable to be seen by our physicians or dismissed from the practice until payments are made. Athena Eye Institute PLLC may reinstate your account once the account is paid in full.

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If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

If the reason for your appointment is related to a work injury or auto accident, you agree to give Athena Eye Institute PLLC the case number or policy number, the workman's compensation or insurance carrier's name, address, or other contact information at the time of your appointment so that Athena Eye Institute can bill workman's compensation or the auto insurance carrier for your visit. If you do not provide this information at the time of the visit, you agree to pay all charges for my visit.

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Athena Eye Institute PLLC. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees, and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges for all services provided to me. I authorize Athena Eye Institute PLLC to deposit checks received on my account when made out in my name.

By signing this form, I indicate that I have read and that I understand Athena Eye Institute PLLC's financial and other policies and I accept responsibility for the payment of any fees associated with my care.

- **Financial Policy:** *I acknowledge that I received, reviewed, and agree to comply with the Athena Eye Institute financial policy, including the financial responsibility and insurance coverage policies found within. I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information.*
- **Vision Plans:** *The practice does not participate in any vision plans.*
- **Assignment of Benefits:** *I hereby authorize payment directly to Athena Eye Institute PLLC for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Athena Eye Institute PLLC, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company or third-party payor.*
- **No Show / Cancellation Policy:** *I acknowledge that I received, reviewed, and agree to comply with the Athena Eye Institute PLLC on cancellation and missed appointments. I agree to pay any fees incurred from failure to comply.*
- **Fee For Forms:** *I understand that I received note about the fees for all forms to be completed by Athena Eye Institute, and I agree to pay prior to form completion.*
- **Privacy Policy:** *I acknowledge that I received, reviewed, and agree to comply with the Athena Eye Institute Privacy Policy.*

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- **Consent to Treat:** *I have the legal right to consent to medical and/or surgical treatment for myself or for the patient. I voluntarily authorize and consent to the medical care, treatment, and testing that providers at Athena Eye Institute PLLC believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses and other healthcare providers in the medical office to provide treatment.*
- **E-prescribing:** *I voluntarily authorize Athena Eye Institute to allow e-prescribing for patient prescriptions. This allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medical dispense history.*
- **Recording / Photo Policy:** *To protect the rights of all patients, Athena Eye Institute does not permit patient recording devices in the examination rooms or common areas. Athena Eye Institute's staff and other patients have the right to their image and likeness; therefore, no patient image or other recording devices are allowed. I understand this policy and agree to comply.*
- **Withdrawal of Consent to Care:** *I understand that I can withdraw my consent at any time by contacting Athena Eye Institute in writing at the office's mailing address. Withdrawal may result in dismissal from the practice.*

Patient or Legal Representative Signature:_____

Date of Signature:_____