



MATTAX-NEU-PRATER EYE CENTER, INC.
MATTAX-NEU-PRATER SURGERY CENTER, LLC
1265 E. Primrose
Springfield, MO 65804

NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER, 2013 UPDATED 3-1-18

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.

UNDERSTANDING YOUR MEDICAL RECORD/PROTECTED HEALTH INFORMATION

Each time you visit our office, a record is made of your visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your medical record or PHI (Protected Health Information).

Mattax Neu Prater and its associates will never:

- Create or maintain a hospital directory
- Create or maintain psychotherapy notes
- Act as a group health care plan
- Market or sell your PHI

Mattax Neu Prater and its associates will:

- Require proof of identity from you or your personal representative if a request regarding your PHI is made
- Reserve the right to deny access or amendments to a records in rare cases. A letter of explanation will sent to you within 30 days of a denial.
- Assume implied consent if you allow a friend or family member to be involved in your examination or any aspect of your treatment.

YOUR HEALTH INFORMATION RIGHTS

Although your medical record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper or electronic copy of the notice of privacy practices upon request
- inspect and copy your medical record as provided for in 45CFR 164.524
- amend your medical record as provided in 45 CFR 164.526
- request an accounting of disclosures of your PHI as provided in 45 CFR 164.528
- request communications of your PHI by alternative means or at alternative locations or completely confidentially.
- revoke your authorization to use or disclose PHI except to the extent that action has already been taken
- a summary or explanation of uses of PHI that are not described in this pamphlet, made available solely upon receipt of written authorization from you
- an electronic copy of health care records when PHI is maintained in an electronic format
- be notified if a breach of confidentiality occurs that involves your PHI. (The extent of information regarding the breach will vary depending on the nature and extent of the breach)
- request amendments to records when errors are identified
- Elect a personal representative who is allowed to request PHI on your behalf.
- File a complaint if you believe your privacy rights have been violated.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your PHI for treatment.

Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

One of the most efficient uses of electronic medical records is for physicians sharing in your care to exchange information.

For example: if you are referred from an ophthalmologist to a specialist, prior information, test results, and photographs can easily be transmitted electronically to you and or the specialist

We will use your PHI for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. For years this has been accomplished with paper via fax, but with electronic records, the information can be sent electronically via a secure connection. Typically, this results in faster payment of the claim.

Agreement for out-of-pocket services

If you elect to pay "out of pocket" for a procedure, service, or visit and request that we **DO NOT** disclose this information to a health plan, we must accommodate this request unless required by law to disclose the information.

We will use your PHI for regular health operations.

For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contracts with Business Associates. Examples include but are not limited to diagnostic services, certain laboratory tests, billing and collection agencies, attorneys and accountants. When these services are contracted, we may disclose your PHI to our Business Associates so that they can perform the job we've asked them to do and bill you or our third-party payer for services rendered. In order to protect your PHI we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Organ procurement organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Disaster Relief organizations: Relief organizations may obtain PHI to coordinate your care and/or locate family members in the event of a disaster

Marketing: The privacy rule defines marketing as making "a communication about a product or service that encourages recipients of the communication to purchase or use the product or service." Generally if the communication meets this definition, then the communication can only occur if we first obtain your authorization. We may NOT sell PHI to a business associate or any third party for that party's own purpose. We will not sell lists of patients without first obtaining written authorization from each patient on the list. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising Efforts: If and when applicable, you will be contacted prior to sharing information for purposes of fundraising efforts. If fundraising is planned you will also be given the opportunity to "opt out" of receiving fundraising communications.

Food and Drug Administration (FDA): We may disclose to the FDA PHI relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Mattax-Neu-Prater Eye Center, Inc., and Mattax-Neu-Prater Surgery Center, LLC are separate legal entities and the sole purpose of combining them herein is to comply with 45 CFR 164.504 (d).

OUR RESPONSIBILITIES

Our organization is required to:

- maintain the privacy of your PHI
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you in the event of a breach of your PHI
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected PHI we maintain.

We will not use or disclose your PHI without your authorization, except as described in this notice.

FOR MORE INFORMATION

If you have questions and would like additional information, you may contact our privacy official, the Clinic Administrator at (417) 886-3937. If you would like to request a copy of your personal PHI you may obtain those forms from our front desk or download from our website at: www.mattaxneuprater.com.

Mail completed forms to the Clinic Administrator who will contact you to determine what information you desire and the reason for the request. If you believe your privacy rights have been violated, you can file a complaint with the Clinic Administrator on forms provided or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint



CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Mattax-Neu-Prater Eye Center, Inc., and Mattax Neu Prater Surgery Center, LLC, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
• A means of communication among the many health professionals who contribute to my care
• A source of information for applying my diagnosis and surgical information to my bill
• A means by which a third party payer can verify that services billed were actually provided
• A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals, and
• A means by which payment for services can be made.

I understand and have been offered a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and will provide a copy of any revised notice. I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC, unless Mattax-Neu-Prater Eye Center agrees to the request in writing.

I understand that for convenience or necessity I would like my health information available to the following friends or family members. I understand if I choose to not list anyone below, absolutely no information about me, my treatment or my bill may be disclosed to anyone except me.

I consent for the following individuals may have access to the following information:

Name: _____ Relationship: _____

- [] All aspects of my care including treatment, diagnosis and billing information
[] Treatment and diagnosis information ONLY
[] Billing information ONLY

Name: _____ Relationship: _____

- [] All aspects of my care including treatment, diagnosis and billing information
[] Treatment and diagnosis information ONLY
[] Billing information ONLY

[] I do not wish to have any health or billing information shared. I understand I will need to pay cash for any services rendered on the day they are performed and no insurance companies will be notified or billed.

I understand that should my circumstances change and I no longer wish the above named to have access to my protected health information, I must contact Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC, immediately.

I fully understand and accept the terms of this contract.

I am a patient or parent / legal guardian of a patient of Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC. I hereby acknowledge receipt of Mattax-Neu-Prater Eye Center, Inc., or Mattax Neu Prater Surgery Center, LLC's NOTICE OF PRIVACY PRACTICES.

Mattax Neu Prater Eye Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient Name (PRINT) _____

Date of Birth: _____

Signature : _____

Date: _____

- [] Patient [] Parent [] Legal Guardian

Health and Medications Information

DOB: _____

Date: _____

Name: _____

Phone: _____

Family Physician: _____

Referring Doctor: _____

DRUG ALLERGY / Reaction: _____

Preferred Pharmacy: _____

Current Medications

Dosage / Frequency

Surgical Procedures within last 5 years

YOUR PAST MEDICAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Acid Reflux Disease (GERD) | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Headache - Chronic |
| <input type="checkbox"/> Anemia - Chronic | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Arthritis - Degenerative (DJD) | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B / C |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> COPD -Chronic Lung Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> CVA - Stroke | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Cirrhosis / Liver Disease | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Collagen Vascular Disease | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> DVT - Deep Vein Thrombosis | <input type="checkbox"/> Pain - Chronic |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Peptic Ulcer Disease (PUD) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Diabetes #years_____ | <input type="checkbox"/> Prostate Enlarged (BPH) |
| <input type="checkbox"/> Dialysis - Hemodialysis | <input type="checkbox"/> Renal Insufficiency - Chronic |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Restless Legs Syndrome |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Graves's Disease | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Anticoagulant Therapy |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Other: _____ |

Eye Problems

- | | Self | Family |
|----------------------|--------------------------|--------------------------|
| Amblyopia (Lazy Eye) | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Astigmatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> |
| Choroidal Melanoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Corneal Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetic Retinopathy | <input type="checkbox"/> | <input type="checkbox"/> |
| High Myopia | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> |
| Strabismus | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Family Medical Problems

- Complication of Anesthesia _____
- Bleeding (Coagulation) Disorder _____
- Cancer _____
- Diabetes _____
- Heart _____
- Hypertension _____
- Migraine _____
- Rheumatoid Arthritis _____
- Stroke _____
- Thyroid Disorder _____
- Other: _____

YOUR SOCIAL HISTORY

- | | Y | N | Frequency / Type |
|--------------------------------|--------------------------|--------------------------|------------------|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you use recreational drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Please indicate special living arrangements below:

- Nursing home Skilled nursing facility/floor Other _____

Name of facility _____

- | | Y | N |
|-----------------------------------|--------------------------|--------------------------|
| Are you currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Advanced directive / Living Will? | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT INFORMATION

PLEASE Complete the ENTIRE FORM – Although certain questions may not seem appropriate for this examination, the answers could be important for care in the future.

Patient's FULL Name			Home Phone	Cell Phone
E-Mail			Send Reminders via: <input type="checkbox"/> Phone <input type="checkbox"/> Text	
Street Address		City, State		Zip
Gender	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Other _____ <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Date of Birth	Social Security No.	
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Eskimo/Aleut <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
Employer (Name/Address)		Employer-Phone	Occupation	
Spouse's FULL Name		Occupation		
Spouse's Employer (Name/Address)		Employer-Phone		
If Patient is MINOR, Father's Name		Employer-Address	Employer-Phone	
Mother's Name		Employer-Address	Employer-Phone	

Referred to This Office by:	Doctor's First and Last Name	Clinic Name	Phone
Primary Care Physician:	Doctor's First and Last Name	Clinic Name	Phone

How Referred: Self Yellow Pages Family/Friend TV Newsletter Newspaper Radio Building Sign

IMPORTANT: Please list the name of someone **not living at home** that would be willing to take a message for you in case we could not reach you at home or work. THIS COULD SAVE YOU A TRIP TO THE OFFICE IF THE DOCTOR IS CALLED OUT ON THE DAY OF YOUR NEXT APPOINTMENT.

Name	Relationship to Patient		
Email	Home Phone	Cell Phone	Work Phone

1. INSURANCE CO. _____ POLICY # _____ GROUP # _____

Mailing Address	City	State	Zip
Policyholder	Birthdate	Soc. Sec. #	
Is this person still working? _____ Retired? _____ How Related _____			

2. INSURANCE CO. _____ POLICY # _____ GROUP # _____

Mailing Address	City	State	Zip
Policyholder	Birthdate	Soc. Sec. #	
Is this person still working? _____ Retired? _____ How Related _____			

Assignment of Benefits and Authorization to Release Information: I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier, to be made on my behalf to Mattax Neu Prater Eye Center for any services furnished to me. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, any insurer(s), and/or the listed responsible person(s), any information needed to determine benefits for the other related services.

Financial Agreement: I accept responsibility for providing correct insurance information at the time of my appointment. I also accept full financial responsibility for all charges not covered by insurance and/or filed with incorrect insurance provided by myself or responsible billing party. I understand that I am responsible for the costs of collection including attorney fees and court costs.

Date _____ Signature of patient (if patient is a minor a parent's signature is required)