SURGERY CENTER
1995 W NASA Blvd
Suite 100
Melbourne, FL 32904

MELBOURNE
1995 W NASA Blvd
Suite 200
Melbourne, FL 32904

ROCKLEDGE
150 South Woods Dr
Rockledge, FL 32955

PALM BAY
5055 Babcock St N.E.
Suite 6
Palm Bay, FL 32905

TITUSVILLE
1709 Garden St
Titusville, FL 32796

Phone: 321-722-4443 * www.seebetterbrevard.com * Fax: 321-722-2334

HIPAA: NOTICE OF PATIENT'S RIGHTS & PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally be kept confidential. HIPAA provides penalties for covered entities that misuse personal health information.

This policy is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA"), for:

Florida Eye Consultants, Inc.,
Eye Institute Surgery Center, LLC,
d/b/a The Eye Institute for Medicine & Surgery
1995 W. NASA Blvd.
Melbourne, FL 32904

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duties:

As required by HIPAA, we will take actions to protect the privacy of your health information for fifty years after the date of death, and to give you this Notice describing our legal duties, privacy practices, and how we may disclose your personal information. We are also required to follow the terms of the Notice currently in effect. Our staff has been trained on the importance of protecting your information, and how to do so. The practice may condition treatment upon execution of this consent.

How We May Use and Disclose Health Information About You:

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- **Treatment**: We will use and disclose your health information while providing, coordinating or managing your health care and related services by one or more healthcare providers.. For example, information obtained by a technician, nurse, physician, or other member of our staff will be recorded in your medical record and used in a manner we determine to ensure the quality of the care that you receive at our offices. In addition to internal use, we may provide this information to other healthcare providers for the purposes of coordination of, or continuity of care. Examples include, but are not limited, your Doctor of Optometry who may have referred you to our office for a medical condition, or your Family Physician, who may have referred you for a diabetic eye examination.
- **Payment:** We will use and disclose your health information as we determine necessary to obtain compensation for providing your health care. Examples include, but are not limited to sending a bill to you or your health insurance providers, or disclosing information about you to your health insurance provider so that your likely eligibility for payment or authorization may be determined in advance of providing a service. The types of information that we may disclose for this purpose includes, but is not limited to information that identifies you, your diagnoses, procedures or tests performed, and supplies used.
- **Health Care Operations:** We will use and disclose your health information to help ensure the ongoing successful operations of The Eye Institute as we determine necessary. Examples include, but are not limited to, quality of care assessments, financial audits, and staff training. This may also include requests for information required by law, such as those relating to Workers' Compensation or because of a subpoena for such information.
- **Law Enforcement:** The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.
- **Marketing Activities**: We prohibit sharing any protected health care information (including names and addresses) with any third party in an effort to receive payment. However, we may contact our patients from time to time, via telephone, mail, email, social media, or other outlets, for the purposes of informing them of services or products that may be of interest or benefit to them, for charitable fundraising purposes, or for educational purposes.
- **Other Uses**: We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

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The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Individual Rights:

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a restriction request except in limited circumstances. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- To inspect or request a copy your health information in a paper or electronic format. If properly authorized, the same information may be given to the patient's designee. You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed. In this unlikely case, you will be notified in writing by our office.

If you have paid for services "out of pocket," in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. Please note, it is your responsibility to notify the pharmacy or DME provider that you do not want the item billed to your insurance company.

Changes to This Notice

This notice is effective as of June 4, 2019, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from our office. You may also obtain a copy of this notice at our website, www.seebetterbrevard.com.

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Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the *"Summary of the Florida Patient's Bill of Rights and Responsibilities – English or Version"* or full text from your health care provider or health care facility.
LOCAL CONTACT: The Eye Institute for Medicine & Surgery; James McManus, MD: (321) 722-4443

Rights:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care, including the credentials of health care professionals and the absence of malpractice insurance if applicable.
- A patient has the right to change providers if other qualified providers are available.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient, or as appropriate, the patient's representative, has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis in order to make informed decisions regarding the patient's care.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to information regarding policies about Advanced Directives.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's right to the extent allowed by the law.

Responsibilities:

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
- A patient in responsible for providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by the provider.

If you have a complaint against a hospital, ambulatory surgical center:

Consumer Assistance Unit: 1-888-419-3456 (Press # 1)
Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive/Bldg. #1
Tallahassee, FL 32308

OR

Accreditation Association for Ambulatory Health Care (AAAHC)
1-847-843-6060
AAAHC Institute for Quality Improvement
5250 Old Orchard Road, Suite 250
Skoki, Illinois 60070

If you have a complaint against a health care professional:

Consumer Services Unit at 1-888-419-3456 (Press # 2)
Agency for Health Care Administration
Consumer Services Unit
P.O. Box 14000
Tallahassee, FL 32317-4000
Website: https://www.cms.gov/Center/Special-Topic/Ombudsman-Center.html

Complaints

You have recourse if you feel that your protections have been violated by our office. You may contact our Privacy Officer to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. All complaints relating to potential violations of this policy will be taken seriously, and investigated in a timely manner. We will not retaliate against you for filing a complaint. Feel free to contact our Privacy Officer in person or in writing, with questions, requests or for further information:

The Eye Institute for Medicine & Surgery
1995 West Nasa Boulevard
Melbourne, FL 32904
Attn: Privacy Officer

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1995 W NASA BLVD., SUITE 100 * MELBOURNE, FL 32904 * PHONE: 321-722-4443 * FAX: 321-722-2334

PATIENT'S ACKNOWLEDGEMENT & CONSENT TO:

"HIPAA: NOTICE OF PATIENT'S RIGHTS & PRIVACY PRACTICES"

By my signature below, I hereby acknowledge that I have received the following document:

1. HIPAA: Notice of Patient's Rights & Privacy Practices

I understand that I am ultimately responsible to make payment for all services provided to me by any of the physicians of Eye Institute Surgery Center, LLC, Florida Eye Consultants, Inc., d/b/a The Eye Institute for Medicine & Surgery. I understand that the practice may condition treatment upon execution of this consent and I agree to abide by all of the related policies of Eye Institute Surgery Center, LLC, Florida Eye Consultants, Inc., d/b/a The Eye Institute for Medicine & Surgery. I understand that I may revoke this consent in writing at any time.

- ☐ I am the Patient
- ☐ If the patient is under 18 years of age, I am the patient's legal guardian.
- ☐ I am the legal guardian or power of attorney holder for the patient.

Printed Name: _____

Signature: _____ **Date**: _____

Witness: _____ **Date**: _____

This acknowledgement page should be retained in the patient's record.
If acknowledgement could not be obtained from patient, the reasons must be documented below.

THE EYE INSTITUTE SURGERY CENTER
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PROTECTED HEALTH INFORMATION RELEASE FORM

It is the office policy of The Eye Institute for Medicine & Surgery not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the examination room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996, as amended in 2013. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, you will need to complete a new copy of this form.)

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. The Eye Institute is permitted to share with them test results and any other information contained in my health record. For copies of medical records, I understand that I will need to sign a separate authorization.

List below those individuals that you wish to receive your protected health information:

Patient Name: _____ **Relationship:** Self **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

Full Name: _____ **Relationship:** _____ **Phone:** _____

☐ **NONE**

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

Sending me email at: _____

Leaving messages on the following numbers:

1) HOME PHONE:_____ 3) WORK PHONE:_____
2) CELL PHONE: _____

Or you may reach me the following ways: _____

I understand that it is my responsibility to update The Eye Institute with any changes in the above listed contact numbers. I understand that this authorization will remain in effect until it is revoked by me in writing.

☐ I am the Patient
☐ If the patient is under 18 years of age, I am the patient's legal guardian.
☐ I am the legal guardian or power of attorney holder for the patient.

Name: _____ **Date**: _____

Signature: _____

Witness: _____

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NOTIFICATION OF POLICY REGARDING ADVANCE DIRECTIVES

The Eye Institute Surgery Center requires the following notice be signed by each patient prior to scheduled procedures in order to be in compliance with the Patient Self-Determination Act (PSDA) and Florida State law and rules regarding advance directives. Advance Directives are a statement that indicate the type of medical treatment wanted or not wanted and who is authorized to make those decisions for the patient. Advance Directives should be made and witnessed prior to serious illness or injury.

The most common advance directives are:

- Living Wills, Durable Power of Attorney for Health Care and Health Care Surrogate.
- For more information please contact www.FloridaHealthFinder.gov or call (888) 419-3456.

If a patient should suffer a cardiac or respiratory arrest, or should some other potentially life-threatening event occur, please be advised that our facility does not honor Do Not Resuscitate (DNR) orders, and it is likely that you will be transferred to an emergency facility offering a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient. These documents can be reviewed and acted upon at the higher level of care. If you disagree, you must address this issue with your physician prior to signing this form.

I currently have an Advanced Directive such as a Living Will, Durable Power of Attorney for Health Care or Health Care Surrogate in place:

☐ Yes ☐ No

I have read and fully understand the Notification of Advance Directives Policy:

☐ I understand that this facility does not honor DNR orders and I agree to proceed with surgery

☐ I wish to reschedule my surgery

☐ I wish to cancel my surgery

Signature: _____ **Date**: _____

This acknowledgement page should be retained in the patient's record.
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EYE INSTITUTE SURGERY CENTER, LLC
1995 W NASA BLVD., SUITE 100 * MELBOURNE, FL 32904 * PHONE: 321-722-4443 * FAX: 321-722-2334

NOTIFICATION OF OWNERSHIP

DISCLOSURE OF OWNERSHIP INTEREST

This Facility is owned by James N. McManus, M.D. and Gary J. Ganiban, M.D., in a corporation that they themselves own.

Please be advised of the following:

- The Facility has a financial relationship with James N. McManus, M.D. and Gary J. Ganiban, M.D., as indicated above.
- You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship.

One reasonable alternative source of service available is:

Name: ASC of Brevard Surgery Center
Address: 719 East New Haven Ave. Melbourne, Florida 32901
Phone: 321 984-4405

I have read and fully understand the Notification of Ownership:

☐ I am the Patient
☐ If the patient is under 18 years of age, I am the patient's legal guardian.
☐ I am the legal guardian or power of attorney holder for the patient.

Printed Name: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

I have received verbal and written notice of my patient rights & responsibilities prior to my procedure:

☐ Yes ☐ No Patient Initials: _____ Date: _____

This acknowledgement page should be retained in the patient's record.
In acknowledgement could not be obtained from patient, the reasons must be documented below.
