

Summary Notice of Privacy Practices
Connie Everett, Privacy Officer · (949) 949-833-8446

Effective Date: December 12, 2002

This notice is a summary of how medical information about may be used and disclosed and your right to access to this information. A copy of the full Notice of Privacy Practices is available in our reception area and may be requested from a staff member.

The law permits us to use or disclose your health information for the following purposes:

- 1. Treatment:** To provide your medical care, your information will be disclosed to employees, other physicians, pharmacies, laboratories, family members and others who are involved in your care. While receiving treatment in open areas, discussions may be incidentally overheard by others receiving treatment.
- 2. Payment:** To obtain payment from your insurance company or health plan.
- 3. Healthcare Operations:** To manage the daily operations of this medical practice.
- 4. Appointment Reminders:** Messages may be left on your answering machine or with the person answering your phone.
- 5. Sign in Sheet:** You may be asked to sign in and your name may be called when we are ready to see you.
- 6. Notification and Communication with Family:** In the case of an emergency, we will use our best judgment in communication with family members.
- 7. Marketing:** To give you information about products or services related to your treatment.
- 8. Other Instances:** Required by law, public health, health oversight activities, judicial and administrative proceedings, law enforcement, coroners, organ and tissue donation, public safety, specialized government functions, change of ownership.
- 9. Worker' Compensation:** For coordinating your care with your adjuster and obtaining payment.

Except as described in this Notice, health information that identifies you will not be used without your written authorization. If you do authorize the use of this information, you may revoke your authorization in writing at any time.

You have the right to:

- Request special privacy protections,
- Request confidential communications,
- Inspect and copy (for a reasonable fee as allowed by California law),
- Amend or supplement,
- Request an accounting of disclosures,
- Make a complaint without penalty.

Please see the complete notice for the procedures for making any of these requests, or phone our privacy officer identified above. We reserve the right to amend this Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

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Please keep this copy for your records.

This is only a copy of Notice of Privacy Practices, and financial responsibility. The original or digital copy will be reserved on file. Note: This Notice of Privacy Practices is provided for educational and informational purposes only. This Notice is not intended as legal advice, and is not provided for adoption or publication by any party. The form and content of any Notice of Privacy Practices should be determined only upon informed consultation with qualified legal counsel. 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. THIS NOTICE IS EFFECTIVE 12/12/02 UNTIL FURTHER NOTICE.

Patient Financial Responsibility

Please initial in the following indicated boxes:

I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my insurer be made directly to the vision care provider. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurer. I certify that the Information I have reported with regard to my coverage is correct. I further authorize this vision care provider to release to my insurer and its agents any information related to this or any related claim.

Acknowledgement of Receipt of Notice of Privacy Practices
Connie Everett, Privacy Officer

Dr. Michael Lipman
949-833-8446

- I hereby acknowledge that I received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.
- I would like to receive a copy of any amended Notice of Privacy Practices by e-mail.
- This medical facility may leave a message on my phone message service at contacts information given phone numbers concerning my medical treatment as needed, unless otherwise indicated. _____
- I understand this medical facility uses email for communication for appointments, monthly newsletter, birthday, and yearly recall for eye health exam. I have an option to opt out at anytime.

Member's signature and Date _____ **Date** _____

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient guardian or conservator of an incompetent patient
 beneficiary or personal representative of deceased patient

Name of Patient: _____