PACIFIC CATARACT + LASER INSTITUTE

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.

Pacific Cataract and Laser Institute (PCLI) maintains a record of the health care services we provide to you. This includes your symptoms, our findings, test results, diagnoses and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use this information to provide care for you but require us to protect the privacy of this information.

PCLI respects your privacy. We understand that your personal health information is very sensitive. **We will not disclose your information to others unless you allow us or tell us to do so, or unless the law authorizes or requires us to do so**. We are required by law to provide to you with this notice of our privacy practices.

Obtaining Your Health Information

- Every attempt will be made to gather your health information in a private manner.
- In the clinic there is a common testing area where it is possible that some private information may be overheard by other individuals who are also being tested.
- In the clinic your examination and counseling will be performed in a private room.
- In the surgery center the preoperative preparations and the postoperative checkout are generally performed in a group setting. In this setting it is possible for others to overhear your name and some aspects of your health care.
- In the surgery center your anesthesia will be provided in a separate room with a privacy curtain at the door.
- In the surgery center your surgery will be provided in a private setting.

How Your Health Information is Used

For treatment:

- Information will be used to help decide what care may be right for you.
- This information may be shared with other health care providers caring for you.
- To comply with federally mandated regulations (found in the Quality Payment Program), Pacific Cataract and Laser Institute allows electronic access to your health records by other independent health care providers, hospitals, and other contracted entities. As a condition for having access to your health care records these other entities all agree to abide by all federal and state laws regarding the privacy and security of your health information.

For Payment:

- Diagnoses, procedures performed, or recommended care is provided to your health insurance plan so that we may receive payment from them.
- You may opt to restrict disclosure of your personal health information to your health plan if you pay for your services at PCLI entirely out-of-pocket.
- If you ask us not to release any of your information to your insurance company(s), we will respect that, and take special measures to be sure not to release your information to your insurance company(s).

For Health Care Operations:

- Information may be used to assess and improve the quality of care we provide.
- We may contact you to remind you about appointments.
- Information may be used to conduct or arrange for services, including:
  - Medical quality review by your health plan
  - Accounting, legal, risk management, and insurance services
  - Audit functions, including fraud and abuse detection and compliance programs

Your Health Information Rights

The health and billing records we create and store are the property of PCLI. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures of your health information. You must deliver this request in writing to us. We are not required to grant your request, but if we can and do grant it, we will comply with your wishes.
- Receive from us a copy of this Notice.
- See and obtain a copy of your protected health information. You may request that this information is provided to you in written or electronic format. Please make this request in writing.
- Ask us to change your health information. Please make this request in writing.
- Receive a list of disclosures of your health information (excluding disclosures to third-party payers).
- Cancel prior authorizations to use or disclose health information. Again, please provide this request in writing.

Our Responsibilities

We are required by law to:

- Keep your protected health information private
- Give you this Notice
- Follow the terms of this Notice

We may change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our facility to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact the ASC Manager at your local PCLI office during regular business hours. You may also deliver a written complaint to our ASC Manager. You may also file a complaint with the U.S. Secretary of Health and Human Services. If you file a complaint, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification to Family and Others

- We will only release your health information directly to you and or your legal guardian.
- We may also give information to someone who helps pay for your care.
- We may disclose health information about you to assist in disaster relief efforts.
- We may release health information about you to a friend or family member but only at your request or with your approval.
- Emergency situations may arise where it is necessary for us to inform your family of your location and general wellbeing. The person contacted will be, if at all possible, the individual you designate to contact in case of emergency.

If you are not comfortable with and do not agree with any of these policies and practices regarding your privacy, please inform us and we will do our best to follow your wishes.

Other Unusual Situations Where Your Health Information May Be Disclosed

- Medical Research - If the research has been approved and has policies to protect the privacy of your health information.
- Eye Banks - When they require information about transplant organs.
- Food and Drug Administration - Relating to problems with regulated products.
- Workers' Compensation – To comply with worker's compensation laws.
- Public Health and Safety Purposes - As allowed or required by law, to prevent or reduce a serious threat to the health or safety of a person or the public.
- Suspected Abuse or Neglect – To report to public authorities.
- Correctional Institutions – As necessary for incarcerated individuals, for your health and the health and safety of others.
- Law Enforcement Purposes – If we receive a subpoena, court order, or other legal process, or you have been the victim of a crime.
- Health and Safety Oversight Activities – For example, we may share health information with the Department of Health.
- Work-Related Conditions that Could Affect Employee Health - For example, an employer may ask us to assess health risks on a job site.
- Military Authorities of U.S. and Foreign Military Personnel - For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings - At your request, or as directed by a subpoena or court order.
- Specialized Government Functions - For example, we may share information for national security purposes.
- In the event of the patient's death we may disclose relevant private health information (PHI) of the deceased patient to a family member, friend, or representative, if that family member,

friend, or person had been involved in the patient's care or payment before death. Unless disclosure would be inconsistent with the patient's express wishes to the practice.

Other uses and disclosures of protected health information will be made only as allowed or required by law or with your written authorization. This includes but is not limited to:

- The transfer of your records to a doctor who is not reasonably believed to be directly involved in your care.
- The transfer of your records in the course of judicial/administrative proceedings at your request as directed by a subpoena or court order.

If There Is a Security Breach That Potentially Affects Your Privacy and Personal Health Information:

We are required by law to:

- Notify you.
- Take steps to mitigate the damage.
- Notify the Department of Health and Human Services (HHS).

Website

We have a website that provides information about us. The address is www.pcli.com.

Acknowledgement of Privacy Practices and Patient Rights and Responsibilities

By signing below, I acknowledge that I have received and agree to the terms in the ***Notice of Privacy Practices*** and the ***Patient Rights and Responsibilities***. I understand that PCLI will protect the privacy of my health information, that I have a right to see this information and correct it, if necessary, and to receive copies of this information. I also understand my rights and responsibilities as a patient at PCLI.

Patient or legally authorized individual signature	*Date*
Printed name	*Relationship (if not self)*

Authorization for Release of Health Information

I authorize PCLI to release my personal protected health information to the following individual(s) or entity(s) without my further consent. ***This authorization automatically expires in 12 months from the date of signature or at any time earlier, if I request***.

Name	*Relationship*	*Phone*
Name	*Relationship*	*Phone*

Patient or legally authorized individual signature	*Date*
Printed name	*Relationship (if not self)*

Authorization of Assignment of Benefits

By signing below, I acknowledge that I wish to have services performed by PCLI, and I agree to be responsible for paying the cost of the services. I request that payment of all medical benefits from my health insurance carrier(s) be made either to me or on my behalf to PCLI for any services furnished to me by PCLI. I authorize any holder of medical information about me to release to any of my health insurance carrier(s) and its agent(s), any information needed to determine the benefits for the services or for related services. ***I understand that this release will remain valid until revoked in writing by myself.***

I further understand that my health insurance carrier(s) may not pay for all services and/or procedures provided at PCLI because they may not be a covered benefit. If this is the case, I understand that I will be responsible for paying for these services.

Patient or legally authorized individual signature	*Date*
Printed name	*Relationship (if not self)*