Austin Ocular Prosthetics Center, LLC
Notice of Privacy Practices in compliance with
HIPAA Rule 45CFR 160 and 164

Effective Date: April 14, 2003

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission. Sometimes the written permission will be called a consent form, and sometimes it will be called an authorization form. The type of permission form will depend upon the kind of uses or disclosures that are involved. In some limited situations, the law allows or requires us to disclose your health information without either a written consent or authorization. The Practice may contact you, either directly or through a business associate, to remind you to schedule an appointment with the Practice. In addition, the Practice may contact you, either directly or through a business associate, to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may use and disclose your health information.

General Statement of Responsibility

The office is required to:

- Maintain the privacy of your health information as required by law (state & federal);
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

Treatment

We use information for treatment purposes, when for example, we set up an appointment for you, when our technician evaluates, fabricates, adjusts, or maintains your ocular prosthesis prescribed by your doctor. We may disclose your health information outside of our office for treatment purposes if, for example, we refer you to your doctor or another doctor or clinic for eye care or low vision aids or services, or when we phone to let you know of your appointment. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

Payment

We use your health information for payment purposes when, for example, our staff asks you about health care plan(s) that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health care plan(s), when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purpose when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health care plan(s), or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

Health Care Operations

We use and disclose your health information for health care operations in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable us to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Other Disclosures

Other Disclosures, We will not make any other uses or disclosures of your health information unless you sign a written consent or authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Right to Inspect and Copy

You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this Health Information, you must make your request, in writing, to our Medical Records Department.

Right to Amend

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing, to our Medical Record Department.

Right to an Accounting of Disclosures

You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Medical Records Department.

Right to Request Restrictions

You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Medical records Department. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Receive Paper Copy of Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, please ask our reception staff.

Right to Receive Confidential Communications by Alternate Means

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our Medical Records Department. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Changes to Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to Austin Ocular Prosthetics Center, LLC management or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Austin Ocular Prosthetics Center, LLC at the address or fax shown at the end of this Notice. If you prefer, you can discuss your complaint in person or by phone.

Austin Ocular Prosthetics Center, LLC
4409 Medical Parkway
Austin, TX 78756
(512) 452-3100 – phone
(512) 452-3200 – fax

I have read your consent policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

_____ _____
Patient Signature Date

_____ _____
Patient Name Printed Authorized Provider Representative