ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

LUKE S. BIANCO, MD
PRIVACY OFFICER
(559) 429-4378

I hereby acknowledge that I received a copy of this medica practice's Notice of Privacy Practices.

Signed: _____

Date: _____

Print Name; _____

Telephone: (____) _____

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: _____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgement refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region I
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (ADD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in

OPHTHALMOLOGY

NOTICE OF PRIVACY PRACTICES

Luke S. Bianco, MD
PRIVACY OFFICER
(559) 429-4378

Effective Date: May 1, 2015

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health *care* clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licenser and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

PLACE LABEL HERE

Luke S. Bianco, MD
Vitreoretinal Disease and Surgery
4004 S. Demaree Street, Suite A,
Visalia, CA 93277
559.429.4378 • Fax 559.623.9630

HEALTH HISTORY

NAME _____ **DATE** _____

MEDICAL HISTORY: (Do you currently or have you ever had problems in the following areas)

YES	NO		YES	NO	
☐	☐	Asthma _____	☐	☐	HIV/AIDS _____
☐	☐	Diabetes (Insulin / Oral Meds) _____ # of yrs	☐	☐	Migraines _____
☐	☐	Head or Spinal Injuries _____	☐	☐	Stroke _____
☐	☐	Heart Disease _____	☐	☐	Kidney Disease _____
☐	☐	High Blood Pressure _____ # of yrs	☐	☐	Rheumatoid Arthritis _____
☐	☐	Thyroid Disease _____	☐	☐	Current Fever _____
☐	☐	Anemia / Bleeding Problems _____	☐	☐	Recent Weight Gain / Loss _____
☐	☐	Carotid Artery Disease _____	☐	☐	**Other Diagnosed Health Problems** _____
☐	☐	Psychiatric _____			_____

Please List all MEDICATIONS You Are CURRENTLY TAKING:
(Include over the counter and Herbal medications)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

We encourage patients that take several medications to submit a typed list.

Please List all FOOD and MEDICATION ALLERGIES:

Do you have an allergy/sensitivity to latex?
☐ Yes ☐ No

_____
_____
_____
_____
_____

SURGICAL HISTORY (Please Include Date and Type)

Surgery: _____
Surgery: _____
Surgery: _____

YOUR OCULAR HISTORY - (Have YOU been diagnosed with any of the following in the past?)

YES	NO	
☐	☐	Amblyopia "lazy eye" _____
☐	☐	Cataracts _____
☐	☐	Cornea Disease _____
☐	☐	Crossed Eyes _____
☐	☐	Glaucoma _____
☐	☐	Injury _____
☐	☐	Iritis _____
☐	☐	Retina Disease _____
☐	☐	Other Eye disorders: _____

_____
_____
_____

SOCIAL HISTORY

Race _____
Marital Status _____
Education Level _____
Current Occupation _____
List your hobbies: _____
_____
_____
_____

YES	NO	
☐	☐	Do you live alone?
☐	☐	Do you drive?
☐	☐	Do you drink alcohol?
☐	☐	Do you smoke?

FAMILY HISTORY - (Has anyone in your family (blood relative) had any of the following?

YES	NO	
☐	☐	Cornea Disease _____
☐	☐	Diabetes _____
☐	☐	Glaucoma _____
☐	☐	Heart _____
☐	☐	Retinal Detachment _____
☐	☐	Retinitis Pigmentosa _____
☐	☐	Stroke _____
☐	☐	Other Eye disorders: _____

_____

☐	☐	Other General Health Problems:

_____
_____

Physician Signature _____

(559) 429-4378 • Fax (559) 623-9630

Luke S. Bianco, MD
Vitreoretinal Diseases and Surgery

In an effort to comply with federally mandated initiatives we are required to obtain specific information from you. Your responses to the information below are protected by HIPAA. This information will only be entered as part of your medical record.

ePrescribing

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe & secure way which protects the privacy of your personal information. ePrescribing software also lets your doctor see important information -- like drug interactions and your prescription history. There are many benefits to you when you're physician ePrescribes such as reduced medical errors, less chance of adverse drug reactions, & fewer trips to drop off a prescription to the pharmacy. Also the doctor can determine if the medication is on the formulary which helps to reduce cost to you the patient.

Patient Consent: I agree that Dr. Luke S. Bianco, MD may request & use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient or Parent/Guardian of Minor Signature _____ Date _____

Pharmacy _____

☐ **I decline & do not allow my doctor to ePrescribe** Address _____

Please indicate the appropriate selection as it applies to you:

Preferred Language

- ☐ Declined Language
- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Romanian
- ☐ Other _____

Race Options

- ☐ Declined race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or other Pacific Island
- ☐ White

Ethnicity Options

- ☐ Declined Ethnicity
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino

Smoking Status

Please indicate the appropriate response as it applies to you. (Does not apply to children under 13)

- ☐ Never smoker
- ☐ Current every day smoker — Date became smoker _____ Date Quit _____ Packs per day _____
- ☐ Current some day smoker — Date became smoker _____ Date Quit _____ Packs per day _____
- ☐ Heavy tobacco smoker — Date became smoker _____ Date Quit _____ Packs per day _____
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked
- ☐ Light tobacco smoker — Date became smoker _____ Date Quit _____ Packs per day _____
- ☐ Former smoker — Date became smoker _____ Date Quit _____

Patient Signature _____ Date _____

Luke S. Bianco, MD
Vitreoretinal Disease and Surgery
4004 S. Demaree Street, Suite A,
Visalia, CA 93277
559.429.4378 • Fax 559.623.9630

PATIENT INFORMATION

Please Print Clearly

EMAIL: ______________________________

PATIENT NAME ______________________________ DATE OF BIRTH __________ AGE __________ SEX ________

HOME PHONE ____________________ BUSINESS PHONE ____________________ MARITAL STATUS ____________

HOME ADDRESS ______________________________ CITY __________ STATE __________ ZIP __________

PATIENT EMPLOYER ____________________ OCCUPATION ______________________________

EMPLOYER'S ADDRESS ____________________ CITY __________ STATE __________ ZIP __________

NAME OF SPOUSE ______________________________ SPOUSE'S EMPLOYER ____________________

SPOUSE'S EMPLOYER ADDRESS ____________________ CITY __________ STATE __________ ZIP __________

PATIENT'S SOCIAL SECURITY NUMBER ____________________ SPOUSE'S SOCIAL SECURITY # ____________________

NAME OF FAMILY PHYSICIAN ______________________________

NAME OF REFERRING DOCTOR ______________________________

NAME AND PHONE OF NEAREST RELATIVE (OTHER THAN SPOUSE) ______________________________

ARE YOU PRESENTLY WEARING GLASSES ______ NO ______ YES HOW LONG ____________

Patient's Signature:

AGREEMENT

I do hereby consent to and authorize the performance of all treatments, surgery and medical services by the physician which he may deem advisable and agree to pay all charges incurred by reason thereof. I authorize the use of photographs in professional presentations to my insurance company, other patients and at medical lectures and seminars. I also hereby authorize release of information requested by my insurance company. I fully understand that this agreement and consent will continue until canceled by me in writing. I hereby authorize my insurance company to pay the doctor directly for any medical or surgical benefits due to me for services rendered which I have not paid. A photostat copy of this authorization is as acceptable as the original.

"I understand that it is policy in this office that payment for services be made at the time of the visit and that payment will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, unless prior arrangements have been made in writing."

The above information is for the purpose of obtaining credit in this office and is warranted to be true. I authorize a representative to make a credit investigation, including employment verification, in the event of non-payment of bills.

DATED: ____________ SIGNATURE: ______________________________

UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________
UPDATED: ________	UPDATED: ________	UPDATED: ________	UPDATED: ________

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MEDICARE/MEDI-CAL AUTHORIZATION

NAME OF BENEFICIARY: _____ HIC NUMBER: _____

I request that payment of authorized MEDICARE/MEDI-CAL benefits be made either to me or on my behalf to Luke S. Bianco, MD, for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In MEDICARE assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE: _____ DATE: _____

PRIVATE INSURANCE AUTHORIZATION

PATIENT'S NAME: _____ SOCIAL SECURITY #: _____

INSURED'S NAME: _____ SOCIAL SECURITY #: _____

I request that payment of authorized INSURANCE benefits be made either to me or on my behalf to Luke S. Bianco, MD, for any services furnished me by their physicians. I understand that I am financially responsible for the charges not covered by this authorization. I authorize any holder of medical information about me to release to my Insurance Company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

SIGNATURE: _____ DATE: _____

Luke S. Bianco, MD
Vitreoretinal Disease and Surgery

POLICIES

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Phone: 559.429.4378
Fax: 559.623.9630

PROOF OF INSURANCE COVERAGE

Luke S. Bianco, MD requires that all patients with insurance coverage provide proof of that coverage. If you are unable to provide the necessary documents (i.e., insurance card) you will be asked to either pay for that day's services or reschedule your appointment. Our office will be happy to bill your insurance company on your behalf once the proper documentation has been received; or, we can provide a copy of the "superbill" in order for you to bill your insurance company directly for reimbursement. In the event, your insurance coverage changes, it is your responsibility to notify our office and provide new proof of coverage.

PATIENT COPAYS

Patients with insurance coverage that have a co-pay are expected to pay their co-pay on the day of service.

HMO PATIENTS

Luke S. Bianco, MD requires from all patient with HMO health benefits an authorization for their first visit. In the event that the patient arrives without having obtained the authorization, it will be necessary to reschedule their appointment. This would also apply to established patients who have not been seen in our office for one (1) year or longer. Patients will be informed of our policy upon making the appointment.

PATIENT RESPONSIBILITY

Patients of Luke S. Bianco, MD are personally responsible for payment of bills. As a courtesy, the office will submit bills to your insurance carriers and/or Medicare. Your insurance coverage is a contract between you and your insurance company, and it is your responsibility to pursue slow payment or non-payment of a claim by contacting the company directly. We will be happy to assist you with any collection problems. However, keep in mind that the bill remains the full responsibility of the patient.

PATIENTS WITHOUT INSURANCE BENEFITS

Patients who do not have insurance will be expected to pay at the time of service unless other arrangements are made in advance. We must insist on monthly payments on all accounts with balances. A bill becomes delinquent after 60 days of no activity. A billing charge may be added for every statement sent to you. To avoid the charge, please pay in full within 30 days.

There will be a $25.00 service charge on all returned checks.

CREDIT AGREEMENT

The above information is for the purpose of obtaining credit in this office and is warranted to be true. I authorize a representative to make a credit investigation, including employment verification, in the event of non-payment of bills.

CANCELLATION FEE

A Cancellation Fee of $25.00 will be charged if appointment isn't cancelled within 24 hours prior to scheduled appointment or consecutively cancelled Twice.

NO SHOW FEE

A "No Show" Fee of $25.00 will be charged if patient does not show for the scheduled appointment.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Patient's Signature

Printed Name of Patient

Office Representative as Witness

Date