HIPAA 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 THIS INFORMATION CAREFULLY.

Note: If you have questions about this notice. Please contact Charm City Optical, 6412 Reisterstown Rd, Baltimore, MD 21215. 410-764-9360. Who will follow this notice? This notice describes the privacy practices of Charm City Optical. All of our staff may have access to information in your chart for treatment, payment and health care operations, which are described below and may use and disclose information as described in the notice. This notice also applies to any volunteer or trainee we allow to help you while seeking services from us.

OUR PLEDGE REGARDING THE PRIVACY OF YOUR MEDICAL INFORMATION:

Your medical information includes information about your physical and mental health. We understand that information about your physical and mental health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and services and to comply with certain legal requirements. This notice applies to any and all of the records of your care generated by us.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revisions or amendments to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. We will post a copy of our current notice in our office in a prominent place.

Financial Disclosure: Charm City Optical charges 12% interest on all accounts past 30 days. Should I default in payment, I agree to pay all cost of collections, including collection agency fees, court costs and any reasonable attorney fees up to 35% of outstanding balance. I authorize Charm City Optical to apply for benefits on my behalf for service rendered and request that payment from my insurance company be made directly to Charm City Optical.

Advanced Beneficiary Notice – This applies to Medicare patients ONLY

Note: If Medicare doesn't pay for D._____ below you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	Estimated Cost:

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above
- Note: If you choose Option 1 or 2 we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

- Option 1. I want the D. ____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice. I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- Option 2. I want the D.___Listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- Option 3. I don't want the D.____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-Medicare. Signing below means that you have received and understand this notice and you also received a copy. By signing this form, I acknowledge I have been given and/or agree to the current HIPAA law practices of Charm City Optical and their financial disclosure. I understand that this financial policy will remain in effect until revoked by Charm City Optical in writing. I acknowledge that I have received a copy of the Patient's Bill of Rights from Charm City Optical.

Signature: _____Printed Name: _____

Parent or legal guardian_____Date:_____