



## HIPAA ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Printed Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

We are required by law to maintain the privacy of and provide individuals with the Notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to the Notice, please inform us either in writing by fax, in person, or over the phone.

If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document.

\_\_\_\_\_  
Signature of Patient or Patient's Representative/Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Patient



## NOTICE OF PRIVACY PRACTICES

---

**THIS NOTICE OF PRIVACY PRACTICES (“NOTICE”) DESCRIBES HOW WE MAY DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.**

---

Your “health information” for purposes of this Notice is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as “health information” in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

### USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment, or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses or contact lenses or medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking about your health or vision care plans or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” means those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personal decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

### OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZED CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine that cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to workers’ compensation programs;
- Disclosures of a “limited data set” for research, public health, or public health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to “business associates” and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA.

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

### **SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION**

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

**Marketing activities.** We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent for such payment.

**Sales of health information.** We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

**Psychotherapy notes.** Although we do not create or maintain psychotherapy notes on our current patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

### **YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES**

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorizations.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

### **YOUR INDIVIDUAL RIGHTS**

You have many rights concerning the confidentiality of your health information. You have the right to:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - Was not created by us, unless the person that created the information is no longer available to make amendment,
  - Is not part of the health information kept by us
  - Is not part of the information you would be permitted to inspect or copy, or
  - Is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated receipt and where to send the copy of the health information.

**Contact Information:**

Dr. Elissa M. Contillo  
671 Atwood Ave  
Cranston, RI 02920  
P: (401) 421-4821  
F: (401) 421-0928

**Complaints:**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 the address or fax shown above. If you prefer, you can discuss your complaint in person or by phone.

**Changes to this Notice:**

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request.

Notice Revised and Effective: 3/29/2022



Thank you for choosing us for your eye care needs.
Please don't hesitate to ask for assistance if you have any questions or concerns.

Patient Information (please print clearly)

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Please choose from the following: [ ] Minor [ ] Married [ ] Divorced [ ] Widowed [ ] Single

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

Insurance Information (patient must provide information for all applicable insurances)

Primary Insurance \_\_\_\_\_ Insurance # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Insurance # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Tertiary Insurance \_\_\_\_\_ Insurance # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Acknowledgement: I authorize and request my insurance company to pay directly to Dr. Elissa Contillo. I understand it is my responsibility to provide the office staff with all accurate and current insurance information. Any balance due that is uncollected from the insurance company because of my inaccurate information becomes my responsibility.

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date

## Heath History

Reason for today's visit: \_\_\_\_\_

Date of Last Physical \_\_\_\_\_ Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Do you or anyone in your immediate family have a history of the following?

	Personal	Family		Personal	Family
Diabetes			Blindness		
Glaucoma			Heart Condition		
Hypertension			Turned/Lazy Eye		

Please check any of the following that pertain to you:

Frequent Headaches  Sinus Trouble  Pregnant  Have given birth in the last 6 months

Please list any medications you are currently taking: \_\_\_\_\_

Please list any allergies (environmental or drug): \_\_\_\_\_

Do you smoke?  Yes  No      Use alcohol?  Yes  No

Have you ever had any of the following conditions involving your eyes?

Eye Surgery  Eye Strain  Flashes or Floaters  Medical Treatment  Eye Injury  
 Poor Near Vision  Poor Distance Vision  Double Vision with Computer Use  
 Extreme Sensitivity to Light  Eye Infection or Disease  Burning, Itching, or Watering

Do you currently wear glasses?  Yes  No

Always  Distance Only  Reading Only  Work Only  Computer

Have you ever worn contact lenses?  Yes  No

Are you interested in wearing contact lenses?  Yes  No

Please list any hobbies or sports: \_\_\_\_\_

**Authorization:** I certify that I have read and understand the above information, and that I have answered accurately. I authorize Dr. Elissa Contillo to release any information including the diagnosis and record of any treatment and examination rendered to me or my child during the eye examination to third party payers and/or health practitioners. Payment for services is expected at the time of the appointment. Payment in full is required to order glasses and/or contacts.

\_\_\_\_\_  
Patient/Parent Signature

\_\_\_\_\_  
Date