NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY OUR PRACTICE, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

This notice describes the privacy policies and procedures of physicians and employees connected with our practice directly, as well as any and all employees of Ophthalmic Plastic Surgery or Interface Aesthetic Surgery. This notice applies no matter which office location you are seen at, as your medical record information is treated the same no matter where that record is physically located.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

Your name, address, and phone number, and other similar demographic information.
Information relating to your medical history, as well as your current medical status.
Your insurance information and coverage.
Information concerning other doctors, nurses or other medical providers who may be involved with your medical treatment in any way.
Information regarding current and possibly historical medication therapies.

In addition, we may gather certain medical information about you from other sources that you authorize from time to time throughout the course of your treatment with us. All of this medical information will be aggregated to create a record of the care provided to you relative to your

course of treatment with us. Examples of the other sources we may go to for information about you and your care may include, but are not specifically limited to, a referring physician, your other doctors, your health plan, and close friends or family members. Much of this information is considered protected health information ("PHI"), and as such is bound by the privacy regulations of HIPAA.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose PHI about you for a variety of purposes. There are four categories of uses and disclosures, which are described below. The examples and explanations shown for each category are merely *illustrations* and therefore should not be considered an all-inclusive listing of potential uses or disclosures.

I. Required Disclosures

When/If requested we are required to disclose information about you to the Secretary of United States Department of Health and Human Services for the purpose of determining our compliance with HIPAA standards and/or to illustrate our privacy commitment to you. You also have a right to access an accounting of disclosures of your PHI. [This right is described below in more detail and a Form will be provided to you for this purpose upon request.] The following list of Public Policy Uses and Disclosures may also be considered *required* disclosures.

- ✓ We may disclose information about you when we are required to do so by federal, state, or local law.
- ✓ We may disclose your PHI in connection with certain public health reporting activities.
- ✓ We are also permitted to disclose PHI to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose information to a person subject to the Food and Drug Administration's for certain activities
- ✓ We may disclose a patient's PHI where we reasonably believe a patient is a victim of abuse, neglect or domestic violence, and the patient authorizes the disclosure or it is required or authorized by law. Your PHI may also be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.
- ✓ We may disclose information about you in connection with certain health of licensing and other oversight agencies.
- ✓ We may disclose your information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body; or to assist with identification by a legitimate law enforcement agency.

- ✓ We may release a patient's PHI (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death; or (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

- ✓ We may release your information as required to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses.

- ✓ We may use or disclose certain information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol, or for other research purposes.

- ✓ If you are a member of the Armed Forces, we may release information about you for activities deemed necessary by military command authorities. We also may release health information about foreign military personnel to their appropriate foreign military authority.

- ✓ We may disclose your PHI for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal.

- ✓ If you are an inmate, we may release your PHI to a correctional institution where you are incarcerated or to law enforcement officials in certain situations

- ✓ Finally, we may disclose PHI for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

II. Treatment, Payment or Operations

For Treatment:

We may use or disclose any/all information gathered from and about you in the course of your treatment. For example, we may use your medical history - such as any presence or absence of diabetes - to assess the health of your eyes; or we might share that same information about you with another medical professional that assists with or consults about your course of treatment.

For Payment:

We may use and disclose information about you to bill for our services and to collect payment from you, your insurance company, or another authorized third party payer. For example, we may need to give a payer information about your current medical condition so that it will pay us for services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval, or to determine whether the service is covered.

For Health Care Operations:

We may use and disclose information about you for the general operation of our business. For example, we may use and disclose your information to review the quality of services provided to you; or to have a professional medical transcriptionist assist with the preparation of portions of your medical record, or to communicate to another provider

involved in your care. Or, for example, we sometimes arrange for auditors or other consultants to review our record keeping practices, evaluate our operations, or tell us how to improve our services.

III. Our Business Associates

We sometimes work with outside individuals and businesses that help us operate our medical practice successfully. We may disclose PHI to these business associates so that they can perform the tasks that we hire them to do. We maintain contractual agreements with our business associates in which they must promise to respect the confidentiality of all your personal and health information.

IV. Disclosures to Persons Assisting in Your Care, or Residing at Your Same Residence

We may disclose information to individuals involved in your care for general information; or more importantly for purposes of making medical recommendations about treatment alternatives. PHI may also be disclosed in recommending health related services that may be of specific interest to you, and/or requested by you. This includes people and organizations that are part of your "circle of care," such as other health care providers involved with your medical care. Treatment Alternatives may also involve PHI communications to others who are potentially a part of your “circle of care,” including your spouse, son, daughter, a parent or guardian (for patients under 18 years of age), or an aide providing services to you.

We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient’s care about a patient’s location, general condition or death.

Finally, we may use and disclose information to contact you as a reminder that you have an appointment or that you should schedule an appointment, but this generally will be basic demographic information only, and will not typically include any medical information about your condition or treatment.

Generally, we will obtain your agreement before using or disclosing PHI in these ways. However, under certain circumstances, such as in an emergency situation, these uses and disclosures may be made without your agreement.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of PHI other than those described above. If you provide us with such permission, you may also revoke that permission, in writing, at any time.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your PHI for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting with the execution of your care, or involved in payment for your care. We ask that you make such a limiting request to us in written form. We will most certainly consider your request, but we are not required to abide by it if it limits our ability to adequately provide treatment, secure payment, or significantly hinder our business operations.

Except under certain circumstances, you have the right to inspect and/or have copies of medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for reproducing and distributing the materials you request.

If you believe that information in your records is incorrect or incomplete, you have the right to ask for corrections to be made to your records. Such requests will be respected whenever possible and appropriate.

At any time you may also request a listing of the ways in which your PHI was used or disclosed outside of treatment, payment or operations. As we were not required to maintain this detailed listing of disclosures prior to April 14, 2003, there may be no listing prior to that date, even if you were a patient of our practice prior to that date. If you ask for disclosure of this information from us more than once every twelve months, we may charge you a fee.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal/protected health information (PHI) we may already have about you, as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be shared with you and made available to you. You may also be asked again to sign and indicate that you were offered a copy of those changes to this notice.

Notice of Privacy Practices

To exercise any of your rights relative to this privacy policy, please contact us in writing at the following address. Please share as much information as possible when making such a request, so that we are sure to fulfill it correctly without processing delays.

Tamara Richardson, Office Manager
Ophthalmic Plastic Surgery
Interface Aesthetic Surgery
200 W 103RD Street, Suite 2020
Indianapolis, Indiana 46290
Attn: Patient Privacy Request

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[Page 7 is a SIGNATURE page only.]

OPHTHALMIC PLASTIC SURGERY
INTERFACE AESTHETIC SURGERY
HIPAA PRIVACY COMPLIANCE

Notice of Privacy Practices

As our Patient, we are offering you this copy of Ophthalmic Plastic Surgery and Interface Aesthetic Surgery's Notice of Privacy Practices to retain for your information/reference. A copy will also be available at any time from our reception desk, or directly from our practice office, and can be shared with you at anytime upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may also contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our Privacy Officer:

Tamara J Richardson, Office Manager
Ophthalmic Plastic Surgery
Interface Aesthetic Surgery
200 W 103rd Street, Suite 2020
Indianapolis, Indiana 46290
Attn: Patient Privacy Request

SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of the Ophthalmic Plastic Surgery and Interface Aesthetic Surgery Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you as well. A copy of this signature page will be provided to you, as well as maintained in your medical chart.

_____ _____
Patient Signature Date

_____
Patient Name – [Printed]

This Notice of Privacy Practices is effective April 1, 2003.

OPHTHALMIC PLASTIC SURGERY
INTERFACE AESTHETIC SURGERY
HIPAA PRIVACY COMPLIANCE

Notice of Privacy Practices

AUTHORIZATION FOR RELEASE OR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ DOB_____

Name of Physician/Practice providing Information:	Name of Person(s) and/or Organization(s) who are being authorized to receive Information:
_____	_____
_____	_____
	_____
	_____

Limitations to this Authorization must be identified below.
If this portion of the form is left blank, it is assumed that the information authorized for release is unrestricted.

Please describe below any restrictions you wish to place on this authorization.
[Restrictions might include limitations as to type of information released; specific dates or period of time involved; or a specific purpose for which the release might apply.]

As a patient I understand and accept the following statements:
I may see and copy the information described on this form if I ask for it, and I can receive a copy of this form after I sign it if I request one. Patient Initials_____

If my physician has initiated this Authorization I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I will not be able to get that treatment without signing this form.

Patient Initials_____

OPHTHALMIC PLASTIC SURGERY
INTERFACE AESTHETIC SURGERY
HIPAA PRIVACY COMPLIANCE

Notice of Privacy Practices

I hereby authorize the release or use and disclosure of my individually identifiable health information (a/k/a Protected Health Information or PHI) as described above. I understand that this authorization is voluntary, I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice, the released information may no longer be protected by federal privacy regulations.

[*NOTE: If a patient is unable to sign for themselves and is underage, or if there is Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as "patient representative*]

_____ _____

Signature of patient, legal guardian or patient representative **Date**

Printed name of guardian or representative:_____

As appropriate, describe guardian's or representative's relationship to the patient:

Witness:_____ Date:_____
[Witness is required if someone other than the patient is signing on behalf of the patient.]