EYE See Clinic by Near Vision Institute

We are a non-profit dedicated to increasing access to Eye Exams, Eyeglasses, Functional Vision Evaluations and Therapy. We are reducing the geographic and financial barriers to care for diverse peoples everywhere. We are coming to your school to provide students with a free eye exam and eyeglasses that will help them in their development, learning, and enjoyment of life.

Parents must complete this Application/Consent form for their student to be eligible for a free eye exam at our Mobile Vision Clinic Event: Online Version: www.EYESeeClinic.org/Consent.php

General Consent: Your Initials Here: _____ YES, I give my informed consent for my child to participate in the Mobile Vision Clinic event.

I understand my child will receive an eye exam and eyeglasses at school, if needed. I authorize the optometrists and other health care providers affiliated with EYE See Clinic to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine/optometry is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by EYE See Clinic. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at EYE See Clinic during the school year during which this consent was signed. I understand that I can call EYE See Clinic at (425) 354-3998 or my school for an opportunity to discuss this program before signing this consent, and any questions I have had have been answered to my complete satisfaction. I understand this is an application for a free eye exam and does not guarantee provision of services at school; EYE See Clinic may need to limit services if demand is greater than our capacity. We prioritize those with Medicaid, Uninsured, and/or known difficulties accessing care in the community.

Assignment of Benefits: Your Initials Here: _____

We require insured patients to complete assignment of benefits authorizing Insurance to remit payment to our office. I hereby assign all medical and/or vision benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: EYE See Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all medical information necessary to secure the payment.

HIPAA Notice of Privacy Practices: _____ (Initial here to indicate that you have read and understand the HIPAA consent on the reverse side of this page and agree with its terms, also available to read at www.EYESeeClinic.org/HIPAA.php)

CHILD'S LAST NAME _____ **FIRST NAME** _____ ☐**FEMALE** ☐**MALE**

CHILD'S DATE OF BIRTH _____/_____/_____ **SCHOOL** _____ **GRADE** _____

ADDRESS _____ **CITY** _____ **ZIP** _____

PHONE _____ **EMAIL** _____

Date of last eye exam: _____/_____/_____ **Needs Eyeglasses ?** _____

Please list any significant medical issues: _____

APPLE HEALTH ID #, or INSURANCE ID: _____

Present vision concerns: _____

Printed Parent/Guardian Name: _____

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices [View this online at www.EYESeeClinic.org/HIPAA.php]

This notice describes how medical information about you or your child may be used and disclosed, and how you can gain access to this information. Please review it carefully. Protected Health Information (PHI), about you or your child, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with EYE See Clinic. Specifically, PHI is information about you or your child, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. EYE See Clinic is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Health Information Rights: Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making any decision about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored offsite, we are allowed up to 60 days to respond but must inform you of this delay. Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We will respond in writing within 60 days of your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: The information was not created by us, or the person who created it is no longer available to make the amendment;The information is not part of the record which you are permitted to inspect and copy; The information is not part of the designated record set kept by this practice? or if it is the opinion of the health care provider that the information is accurate and complete. We will respond within 60 days, in writing, explaining of the request was accepted or denied. Request an alternative means of confidential communication: You have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, {using a form provided by our practice}, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests. Request a restriction of your PHI: This means you have the right to ask us, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction. An accounting of Disclosure: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12month period will be free. If you request an additional list within 12months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will accommodate all reasonable requests. A Paper copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit by calling and asking us to mail you a copy. File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us, or directly to the Secretary of Health and Human services. U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 1-877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints/ Authorize other use and disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization. We may contact you to provide information about health related benefits and services offered by our office, for fundraising activities, share information in a disaster relief situation, include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in Which We May use and Disclose Your Protected Health Information: The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health Information fall within one of these categories. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example we should disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment. Health care operations: We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform billing, consulting, or transcription services for our practice. Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example we may include information with a bill to a third party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service. **Other Ways We May Use and Disclose Your Protected Health Information:** Public health: We will use and disclose your protected health information in certain situations to help with public health and safety issues. Some of the situations include: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. As Required by Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures. Other Permitted and Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes: To comply with Food and Drug Administration requirements, Legal proceedings, Coroners, Funeral directors, Organ donation, Criminal activity, Military activity, National security, Worker's compensation, When an inmate is in a correctional facility, If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. By signing this form you acknowledge you were advised of the HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.