Policies, Consent, and Signatures

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2013, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to an optician, ophthalmologist or other healthcare provider providing treatment to you for: a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; (c) the referral of a patient for health care from one health care provider to another; or (d) recall information.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or

reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information

to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to 01/01/2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and

provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: Corrie Bryan

Telephone: 406-522-8888 Fax: 406-404-1885

E-mail: info@20Twentymt.com

Address: 280 W Kagy Blvd Ste B Bozeman MT 59715

20Twenty Eyecare Financial Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable healthcare. This billing process notification is developed to assist you with understanding your rights and responsibility when receiving services with 20Twenty Eyecare.

Insurance: 20Twenty Eyecare participates in most insurance plans, including Medicare. If you are not insured by a plan, payment in full is expected at each visit. If you are covered by a participating plan, but you are either missing an updated insurance card or you cannot provide policy and group number, you will be responsible. You will be required to pay for your visit in full until our office is able to confirm your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance: All patients must confirm and/or complete a patient information form before being seen. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct

insurance information in a timely manner, you may be responsible for the balance of a claim.

Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You are responsible for payment for these services.

Change in Insurance Plans: You are expected to notify our office if your insurance coverage changes. We will ask you to update your record at each visit to our office. It is also your responsibility to notify the
office immediately of these changes. Balances left over 90 days will become the responsibility of the patient. Insurance carriers give us a 90-day period to submit claims to them for payment. After that
time, it will be denied as past timely filing. If we are unable to process your claim due to incorrect information given, we will bill you directly for our services.

Claims Submission: We will submit your claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If payment is denied due to a lack of response from you, the balance will immediately become due and payable by you. Your insurance benefit is a contract between you and your insurance company. We are not party to the contract.

Payment is Required at the Time of Service: Patients who are not covered by health vision insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay at the time
of service. Patients who have plans that we do participate with are asked to pay their co-payment, co-insurance, deductibles, or non-covered services at the time of their visit.

Self-Pay: We want to provide uninsured patients with quality and affordable healthcare. Most of our billed charges will be discounted for self-pay patients. In order for us to offer these rates, payments must be made in full at the time of service before leaving the office. No further discounts will be given. This discount does not apply if insurance is or has been billed. The self-pay discount does not apply to co-pays, deductibles, or non-covered services.

Nonpayment: Should your account become 90 days delinquent, you will receive a letter stating that you have 10 days to pay your account in full. Patient payments will not be accepted unless otherwise negotiated with a member of our business office. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. The patient or guarantor will be responsible for all costs of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35 percent. The contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Third Party Billing: We will submit to 3rd party billing as a courtesy if the patient has all

necessary information. If payment is not received within 90 days, it will be the patient's responsibility to seek reimbursement and will fall under the self-pay guidelines.
Flex/Cafeteria Plans: Payment is due at the time of service. We will provide a "paid" receipt to self-submit for reimbursement.
Minors: For all services rendered to minor patients, the patient or guardian who brings the patient to the appointment is responsible for payment.
Products/Materials: We prefer full payment for any product or materials ordered and will require at least 50% down upon ordering with the remaining balance due at dispensing time. 20Twenty Eyecare is dedicated to making each pair of glasses fully customized to your visual needs. We want you to love your glasses, however since each pair of lenses is customized, there will be a 25% restocking fee for the return of any products/materials prior to 30 days. Products/Materials purchased after 30 days are non-returnable and nonrefundable.
Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions.

Consent to Treatment

I hereby voluntarily consent to the rendering of such care, including diagnostic procedures and treatment, by authorized members of the 20Twenty Eyecare staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition. I have read this form and certify that I understand its contents. I hereby give our (my) consent to: 20Twenty Eyecare for treatment. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this period. I further agree to pay all charges at the time of check-in for each appointment.

20Twenty Eyecare HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health
Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you

consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:
• Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
• The practice reserves the right to change the privacy policy as allowed by law.
• The practice has the right to restrict the use of the information, but the practice does not have to agree to those
restrictions.
• The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by:

_____

(PRINT NAME PLEASE)
Signature:

_____

Date: _____

Please check, sign, and date that you have read and agree to our consents/policies and click the SUBMIT button to complete your online forms. Thank you!