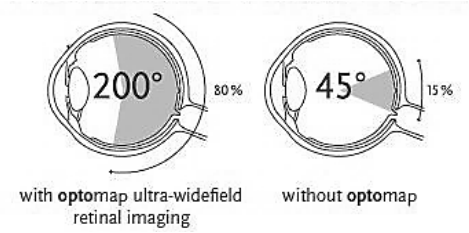
PLEASE READ THIS ELECTRONIC SIGNATURE CONSENT BEFORE YOU PROCEED.

Your electronic signature shall have the same force and effect as an original signature and shall be deemed
(i) to be "written" or "in writing" or an “electronic record”
(ii) to have been signed and
(iii) to constitute a record established and maintained in the ordinary course of business and an original written record when printed from electronic files. Such paper copies or "printouts," if introduced as evidence in any judicial, arbitral, mediation or administrative proceeding, will be admissible as between the parties to the same extent and under the same conditions as other original business records created and maintained in documentary form.

Retinal Examination:

- An important part of your eye exam, is the retinal evaluation. It enables the doctor to evaluate the health of your body by looking at the blood vessels, nerves, and other layers inside your eye.
- This evaluation is recommended once a year for all patients.
- The doctor requires this test for
    - Patients with vascular diseases (Diabetes, High Blood Pressure, High Cholesterol)
    - Patients with high myopic prescriptions (Over - 4.00)
    - Patients over 40 years of age.
    - Patients using medications that have ocular side effects (e.g. Plaquenil, Ethambutol, Topamax, Flomax, Blood Thinners, and herbal supplements)
- You may either get your eyes dilated using eye drops, or use the OPTOMAP retinal imaging system. The OPTOMAP Imaging System is a fast, Comfortable, and Painless digital imaging of the retina without the use of eye drops:



Please select one of these two options:

☐ I would like **Optomap retinal imaging**. I agree to the **$39.00 fee** for service. I understand that this technology is not covered by my insurance.

☐ I prefer dilation with eye drops. I understand that my near vision will be blurry, and my eyes may be light sensitive for up to 6 hours. I understand that I am not supposed to drive more than 5 miles, or operate any machinery until I feel like my vision has suitably recovered.

ELECTRONIC SIGNATURE (Guardian if under 18 years of age):
DATE:

Examination and Billing Protocols

- Payment is due in full at the time of service and purchase. Payments made toward services offered at Elite Family Vision and Richmond Eye Experts are non-refundable.
- You must present your insurance information before or on the day of your visit. The decision to bill your vision insurance vs. your medical insurance depends on the reason for your visit and severity of eye condition when you present for your exam.
- Your complete comprehensive eye exam will be conducted at the time of your appointment. Declining the internal eye exam will require a signed consent and is NOT ADVISED. Delaying the internal eye exam to another day will incur additional fees.
- **Contact Lens exams will involve additional fees.** These fees are dependent on your insurance company. Please ask the staff for details. If you sign up for a contact lens exam, this fee will be collected even if you do not purchase the lenses, or complete the fitting process. Contact Lens exams may require follow up exams on a separate date for no extra charge. Follow up exams should be maintained as scheduled, and prescriptions should be finalized within 30 days of the initial visit. If the process takes longer due to noncompliance with follow up exams, then there will be an additional contact lens examination fee payable by the patient.

Optical Policies – Richmond location only

- If you are not comfortable with your glasses, we will do **one complimentary prescription recheck and remake within 30 days of the initial eye exam**. There will be a $35.00 refraction fee for prescription verifications after 30 days of the visit. Rechecks and Remakes will NOT be provided after 2 months of the exam. This will be considered a new exam and new eyewear purchase.
- A $25 Warranty is available for your eye wear purchase. This warranty will cover ONE replacement of frames and/or lenses with applicable copays. Please ask associate for details.
- Payments made toward Eyewear offered at Richmond Eye Experts are non-refundable. These are custom made and not returnable.
- If you wish to change your frame, there will be ad addition charge of $100.00 plus the cost difference between the frames.
- If you wish to change your lens treatments, a new lens will be provided at a discounted rate.

Patient Owned Frames – Richmond location only

- We are not liable for any damage that your frame may incur. We can only guaranty the quality and durability of the frames from our optical. We recommend a frame from our in-house collection which will be warrantied for breaks or damage. Used, old, or non-optical frames are more likely to bend or break during lens insertion.
- Your frame may be discontinued by the manufacturer in which case we will not be able to order the same one for replacement.
- If your frame breaks during handling, new lenses will be provided at a discounted rate. The purchase of the new frame will be at your expense.

Notice of Privacy Practices: PLEASE READ CAREFULLY

- We will use your health information for referrals to other physicians for your continued care, to provide appointment reminders, prescribe or recommend treatment alternatives, and provide information about health benefits and services that may be of interest to you.

- We will email your prescriptions and referrals via the patient portal to the email address you have provided on this form. We are unable to merge portals or change email addresses over the phone.
- Please review the complete patient privacy notice. Signing this document acknowledges that you were offered the opportunity to review this policy.

Authorization and Consent: PLEASE READ CAREFULLY

- I certify that I have filled out the patient information form accurately and to the best of my knowledge.
- I authorize the eye doctor to release any information including the diagnosis and records of any care rendered to me, to third party payers/ health practitioners for the purposes of checking eligibilities, payment or continued care.
- I attest that the address, phone number, and email address provided is mine, and Elite Family Vision or Richmond Eye Experts can contact me to remind me of appointments, mail patient information including prescriptions, Optomap images, and balance payable notices to any of the above.
- I authorize and request my insurance company to pay directly to the eye doctor, the benefits otherwise payable to me. I understand that my insurance carrier may pay less than what is billed, **and I may be responsible for uncovered balances, copays, coinsurance payments or deductibles that are not covered under insurance contracted amounts.**
- I understand that if the insurance company accidentally pays me directly for the services, I will issue a payment to the billing facility.
- I understand that I will not receive prompt pay discounts or special pricing when I use my insurance for payment toward the eye exam.
- I understand that there are no refunds for professional services rendered. Prescription glasses are custom made products, and as such, once the order is transmitted to our lab, it cannot be cancelled or refunded at any time.
- I hereby authorize Elite Family Vision PLLC or Eye Experts PLLC DBA Richmond Eye Experts to bill my vision and/or medical insurance on my behalf and collect payment for services rendered.
- **My balances may be forwarded to a collection agency if not paid within 90 days after three attempts to contact me via phone, text, or email. An additional administration fee of $25 will be added to bills that require to be mailed.**
- I understand that this office is HIPAA compliant and acknowledge that the HIPAA policies are available to be read if requested. This authorization and consent to use my Protected Health Information is valid for 6 years until revoked in writing.
- I understand that Elite Family Vision or Richmond Eye Experts may refuse treatment if I do not consent to the above protocols, notices, and authorizations.

ELECTRONIC SIGNATURE (Guardian if under 18 years of age):
DATE:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR 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, contact lenses, or eye 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 you 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" mean 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; personnel 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 AUTHORIZATION OR 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 the 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 worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or 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 to such payment.
- Sale 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 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 authorization.
- 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 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 (See Contact Person).
- 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:
    - If it was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for 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 and may not include dates before July 11, 2013. 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 recipient and where to send the copy of the health information.

CONTACT PERSON

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Jordana Chettiparampil O.D.

7770 W. Grand Parkway S, Suite B-1, Richmond, TX 77406

Phone: 8327681765

Fax: 2812208522

Email: info@richmondeyeexperts.com

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 office contact person at the address, fax or E mail 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 at our reception area.