SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Patient Registration Information

Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: Female ☐ / Male ☐ Marital Status: Single ☐ Married ☐ Widowed ☐ Other ☐

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Are you a Veteran? Yes ☐ / No ☐

Emergency Contact: _____ Relation to Patient: _____

Phone: _____ Email: _____

Eye Physician: _____ Primary Care Provider: _____

Eye: RT ☐ / LT ☐ _____

Date of Injury: _____ **Date of Surgery:** _____

Primary Insurance: _____ ID# _____ Group# _____

Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ ID# _____ Group# _____

Policy Holder: _____ Policy Holder DOB: _____

Authorization to Release Information: I authorize **Southeastern Ocularists, Inc.** to release information and medical records to insurance carriers or physicians during the course of my examination and treatment.

Assignment of Benefits: I hereby assign **Southeastern Ocularists, Inc.** all payments for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this original shall be considered valid as the original.

Financial Agreement: We request that payment be made at the time professional services are rendered. Any services not paid for in full at time of the visit must be coordinated with insurance. You are responsible for any payments or co-payments not paid by your insurance company.

We are a contracted Medicare provider. If you are covered for prosthetic eyes under your Medicare plan, Medicare will pay you directly 80% of the allowed charge after your yearly deductible with Medicare has been met. You will be responsible for all payments at the time services are rendered, since Medicare will be paying you directly. You will also be responsible for all charges over the Medicare allowed amounts.

A service charge of $25.00 will be charged for all checks returned for insufficient funds or for any other reason.
If you have any questions, please feel free to discuss them with us.

By my signature below, I am agreeing to the Authorization to Release Information, Assignment of Benefits, and the Financial Agreement.

_____

Signature of Patient/Authorized Representative Date Signed

SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our patients review and sign this Communication Consent Form.

Southeastern Ocularists, Inc will not release confidential and/or other Protected Health Information (PHI) without consent by home mailing, home telephone, work telephone, cell phone, voicemail, text or email. When we place phone calls and the voicemail responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the patient. Information will also not be left with an unauthorized person who may answer the telephone.

I, _____ authorize Southeastern Ocularist, Inc to contact me and/or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify Southeastern Ocularists, Inc whenever this information changes:

☐ Mail Address: _____
☐ Phone #: _____
Can we leave a detailed Voicemail? Yes☐ No☐
☐ Text #:_____
☐ Email Email Address: _____

List of **Authorized Persons** that can receive confidential and/or Protected Health Information (PHI) on your behalf:

_____
_____
_____

We send Automated appointment reminders for our patients. Please select your preference:

☐ Phone Phone #: _____
☐ Text Phone #: _____
☐ Email Email Address: _____

We also offer to send to a reminder to schedule check up appointments. Please select your preference:

☐ Postcard Address: _____
☐ Phone Phone #: _____
☐ Text Phone #: _____
☐ Email Email Address: _____
☐ I Do Not Consent to Receive Reminders to Schedule Appointments

_____
Printed Name of the Patient

_____
Signature of Patient/Authorized Representative Date Signed

SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Authorization for the Release of Medical Records

I, the undersigned, hereby authorize _____ to release the medical records of:
(Regular Eye Physician)

Patient Name: _____ DOB: _____
Address: _____
Phone Number: _____ Last four digits of SSN: _____

To: Southeastern Ocularists, Inc
Mailing Address: 3020-I Prosperity Church Rd #638, Charlotte, NC 28269
Phone: 704-510-9292 Fax: 704-510-9881
Email: admin@seocularist.com

Purpose of Request: To obtain prior authorization and for use as proof of medical necessity with regards to the patient's insurance only.

Information Requested:

□ Progress Notes □ Operative Reports □ Hospital Reports

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing, except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

I understand that these records are protected under Federal and/or State Law, and cannot be disclosed without my written consent, unless otherwise provided by law.

By my signature below, I hear by, knowingly and voluntarily, authorize Southeastern Ocularists, Inc to request my health information.

_____
Printed Name of the Patient

_____
Signature of Patient/Authorized Representative Date Signed

SOUTHEASTERN OCULARISTS, INC.
Custom Made Ocular Prosthetics

Acknowledgement of Receipt of Notice of Privacy Practices

Complaint Protocol

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the Medicare Beneficiaries Complaint Log, and completed forms will include the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company. The patient will be informed of this complaint resolution protocol at the time of set up of service.

Statement of Warranty

Every product sold or rented by our company carries a one-year manufacturer's warranty. Southeastern Ocularists, Incorporated will notify all beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Southeastern Ocularists, Incorporated will repair or replace, free of charge, equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

Notice of Privacy Practices

(See Attached Handout)

I have been instructed in and understand the complaint protocol and the warranty coverage on the product I will/have receive(d). I also acknowledge that I have received a copy of the Notice of Privacy Practices for Southeastern Ocularists, Incorporated. I have also received educational information on the care of my prosthesis.

_____

Signature of Patient/Authorized Representative Date Signed

CHARLOTTE LOCATION
8426 Medical Plaza Drive # 500
Charlotte, NC 28262
704.510.9292

MT. PLEASANT LOCATION
1300 Hospital Drive #260
Mt. Pleasant, SC 29464
843.884.7113

704.510.9881 | www.seocularists.com

Mailing Address: 3020-I Prosperity Church Rd #638, Charlotte, NC 28269

MEDICARE DMEPOS SUPPLIER STANDARDS (Medicare Patients Only)

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records. 8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations. 11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number, i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics

MEDICARE DMEPOS SUPPLIER STANDARDS DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary. The products and/or services provided to you by Southeastern Ocularists, Inc are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards

Signature of Patient/Authorized Representative Date Signed

Southeastern Ocularists, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Contact Info: 3020-I Prosperity Church Rd #638, Charlotte, NC 28269 Phone# 704-510-9292, or Fax# 704-510-9881 ATTN: Samantha/Jeanie

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; referring you to another doctor or clinic for eye care; or getting health information from another professional that you may have seen before us. Examples of how we use your health information for payment purposes are: asking you about your health 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 have to do 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 and legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission.

USE AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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 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 officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health 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 health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping with your eye care.

APPOINTMENT REMINDERS

We may call, text, write, or email to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions you want. To ask for a restriction, send a written request to the office contact, person at the address or fax shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send us a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by lay and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change the Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

COMPLAINTS

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

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.