Garrick Sit, O.D.
441 S Escondido Blvd.
Escondido, CA 92025
(760) 741-7497

NOTICE OF PRIVACY PRACTICES

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

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

EFFECTIVE DATE OF NOTICE: January 1, 2013

Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Escondido Optometrix can use your protected health information for treatment, payment, and healthcare operations.

a) Treatment – We may use or disclose your health information to a physician or other health practitioner providing treatment to you.
b) Payment – We may use or disclose your health information to obtain payment for services we provide you.
c) Healthcare operations – We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment or healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity or emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

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 victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, letter, or e-mail.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). Request for restriction may be denied if the information is required for treatment, payment, or healthcare operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Escondido Optometrix is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints

If you have any complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information

For further information about our privacy policies of Escondido Optometrix, please contact Dr. Sit at the following address or phone number:

Escondido Optometrix
Garrick Sit, O.D.
441 S Escondido Blvd
Escondido, CA 92025
(760) 741-7497

NOTICE OF PRIVACY PRACTICES

Due to The Health Insurance Portability and Accountability Act (HIPAA), we are obligated by law to give you notice of our privacy practices. Please read them, then sign here.

I acknowledge that I have read and understand Escondido Optometrix's Notice of Privacy Practices, and will be given a copy per my request.

Patient Name_____
(Please Print)

Signature_____ Date_____
(If under 18, parent/legal guardian signature)

INFORMED CONSENT FOR DILATION

Dilated Pupil Examination – A procedure in which eye drops are instilled onto the ocular surface to widen the pupil. This allows an improved view of structures inside the eye. The doctor can inspect for abnormalities some of which can potentially threaten your vision: **Done at no additional charge.*

Is recommended for –

- First eye exams or have never been dilated previously.
- Been over 2 years since last dilation.
- Every year for those with systemic disease (i.e. diabetes, hypertension)
- Family history of ocular or systemic problems

Medications Used – This can vary depending on the type of testing required. The most commonly used drops are Mydriacyl and Phenylephrine.

Side Effects – The most common symptoms are blurred vision at near and sensitivity to light. Most patients can drive themselves afterwards. If you have any concerns about driving immediately following this procedure, re-scheduling arrangements can be made. Disposable sunglasses will be provided at the completion of this procedure.

I have been given a clear explanation of the procedure and the potential side effects.

Signature_____ Date_____

AUTOMATED VISUAL FIELD TESTING

Visual Field Testing – This is a computerized test used to evaluate your peripheral vision. Certain eye diseases and neurological conditions can affect one's side vision. A visual field test can be helpful in detecting such disorders. Administering this test takes about 3 minutes per eye.

Is recommended for –

- All first time patients
- Patients experiencing consistent headaches, dizziness, nausea, vomiting
- Family history of ocular disorders or neurological diseases

Please check one –

- Yes, I would like this test performed
- No, I would not like this test performed
- I would like more information about this test

There is an additional fee of $25.00 for this test Please note: Most vision plans already include this test, please ask our staff.