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AGREEMENT AS TO RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center, I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center.

Should I initiate or pursue a meritorious medical malpractice claim Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center for professional care, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists in the same or similar specialty Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's specialty society.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration Stephanie Ross, OD, Resident, Flana Levando, OD, Resident, Christine Hair, OD, Daniel Ochs, OD, Jessica Mark, OD, Eric Fazio, OD, Mike Stuntz, MD, James Doyle, MD, Courtney Bovee, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center also agrees to exactly the same previously referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Date of Signature: _____

Effective from Date of Treatment: _____

Patient Name : _____

Physician: _____

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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4211 US Highway 27 N, Sebring, FL 33870 (863) 385-1544
13904 N Dale Mabry Hwy, Suite 200, Tampa, FL 33618 (813) 908-2020
113 S. Armenia Ave., Tampa, FL 33609 (813) 908-2020
www.NEWSOMEYE.com

Acknowledgement of Receipt

By signing this document, I acknowledge that I have reviewed and/or requested a copy of the patient paperwork packet of Newsom Eye. This packet includes the following:

Please circle YES (Y) or NO (N) to applicable questions below.

- **Financial Policy** – I have read and understand the Financial Policy and agree to meet all financial obligations.

- **Lifetime Authorization** (1st & 2nd Sections) – Medicare or Insurance Certification for Payment.
  - Do you belong to a Health Maintenance Organization (HMO)? **Y N**
  - Do you need approval for your Primary Care Physician (PCP) before you can be seen by an ophthalmologist/optometrist? **Y N**

- **Do we have permission to**:
  - Send a recall appointment reminder to your home **Y N**
  - Leave appointment, billing or treatment information on your voice mail, phone via text message or e-mail **Y N**
  - I give permission to share appointment, billing or treatment information with the person named below:

  Name: _____

- **Refraction(s)** – I understand that a portion of my examination is not covered by Medicare/Most Insurance Plans and does not include this as of your integral exam (Refraction is $45.00)

- **Agreement as to Resolution of Concerns**
- **HIPAA Notice of Privacy Practice -** Disclosures of Protected Health Information

Print Name: _____

Signature: _____

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FINANCIAL POLICY CONSENT FORM

The doctors and staff at Newsom Eye & Laser Center (NELC) would like to thank and welcome you to NEWSOM EYE. Our goal is to provide you with NEWSOM EYES!

Please read the Financial Policy, outlined below, and ask any questions you may have, and initial where requested:

1. NELC will submit your claims, however, we must emphasize that as medical providers, our relationship is with you, not your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and cannot possibly know all of the details or specific benefits allowed by your insurer. Although we attempt to verify your medical benefits with your insurance company, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry. If your insurance company fails to pay any part of your claim you will be responsible for that unpaid balance in full. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment. It is your responsibility to inform us if your insurance requires pre-certification or pre-authorization of services prior to the scheduling of such services. As such, you will be responsible for services denied for reasons including, but not necessarily limited to, "No Eligibility", "Non-Covered Service", and "Pre-authorization/certification Not Obtained." Statements are sent after your insurance has paid, denied, or determined non-payment.

2. It is your responsibility to inform NELC of any information changes in order to keep your account current at all times.

3. All self-pay payments, insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover and CareCredit. If you do not have payment(s), your appointment may be rescheduled. You may be asked to schedule another appointment for services other than the reason for your original appointment.

4. A returned check will result in a minimum of $25 service charge, see schedule below, and all future payments being required in the form of cash, credit card, or CareCredit.

Amount of check	Service Charge
$50.00 or less	$25.00
$50.01-$300.00	$30.00
$300.01 or greater	$40.00 or 5% of the face amount of the check, whichever is greater.

5. Refund checks will be issued for credit amounts over $50.00 after insurance has processed. If your credit amount is less than $50.00, that balance will be applied to future visits.

6. Any unpaid balances older than 30 days may be subject to 1.5% interest per month. If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees. This will occur after we have exhausted all of our standard internal collection efforts and have not received any payment for services rendered.

7. Not all services are a covered benefit with all insurance companies (ex: refraction for glasses). It is your responsibility to be aware of what services are being provided to you and if it is a covered benefit under your insurance.

8. Referrals: Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain a proper referral in order to be seen for your appointment. If you don't have a referral at the time of your appointment, you may be rescheduled and you could be charged a missed appointment fee of $30.

9. All non-prescription sunglasses are final sale items. These cannot be returned or exchanged. All prescription glasses and sunglasses are subject to a 30% restocking fee should they need to be exchanged or returned.

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FINANCIAL POLICY CONSENT FORM

10. Medicare patients: We will bill Medicare for you. All co-payments are due at the time of service. You will be responsible for any balance not paid by Medicare and secondary insurance.

11. Email and Text Message Reminders: If you provide your email and a mobile phone number, you consent to receive promotional or notification emails and you consent to receive text messages about your upcoming appointments, bill payment, review requests, etc.

12. **EFFECTIVE 01/01/2019** Missed Appointments: Please provide at least 24 hours' notice to cancel an appointment. We do this so your appointment slot can be offered to another patient in need of attention. You may be charged a $30 fee if your fail to keep your appointment or cancel with less than 24 hours' notice.

13. Online Review Consent: In the event that I post a review or testimonial regarding my experience at Newsom Eye on any social media or review platform including but not limited to Google, Yelp or Facebook, I consent to allow Newsom Eye to use the review on their website (newsomeye.com) once my name as the author has been de-identified and removed from the review before posting.

14. In the event any provision or part of this policy is found to be invalid or unenforceable, only that particular provision or part so found, and not the entire policy, will be inoperative.

Int._____Credit Card on File Policy: WE ASK THAT YOU KEEP A CREDIT/DEBIT/HSA CARD ON FILE to be used for any unpaid balances. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary at our organization. Please keep in mind, we will not charge your card if you do not owe anything. Once your credit card information is entered into our Practice Management System, it is encrypted and safely stored by our Practice Management System and the information is not accessible by anyone at our offices. By signing this agreement, you understand that once the insurance company has paid their portion for care that you will receive an Explanation of Benefits (EOB). This EOB will state any balance remaining to be paid by the patient. NELC may charge your credit card the balance due when we receive a copy of the EOB. Charges will be made after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. If the charge exceeds $250 you will receive a courtesy call informing you of the charge. Circumstances when your card would be charged include, but are not limited to, missed co-payments, co-insurance and deductibles, and non-covered services and/or denial of services.

Int._____If the credit card we have on file for you changes, please notify us immediately by calling our office at 1-855-908-2020 ext. 603. It is not uncommon for people to change or cancel their credit cards, including when it expires. If we run your credit card and it is denied for any reason, we reserve the right to charge you an additional $25 declined charge fee if we are not able to run a new credit card within 7 days. We will call you at the number on file and leave a phone message if this occurs.

If you have any questions regarding this information, please call our Billing Department at 1-855-908-2020 ext. 603.

Please feel free to contact Medicare or your insurance company for prior authorization or predetermination of cost prior to your receiving care.

By signing below, you confirm you have read and understood the above Financial Policy, Missed Appointment policy, and the Credit Card on File Policy, have had all of your questions answered, and you agree to meet all financial obligations.

Signature: _____ Date: _____