

THE EYE INSTITUTE

Eye Associates of Wayne P.A.
968 Hamburg Turnpike
Wayne, NJ 07470
973-696-0300
fax 973-696-0465

Dear Patient:

Welcome to The Eye Institute. Our mission is to provide you with the highest level of medical care. Our doctors are ophthalmologists and optometrists, trained in the diagnosis and treatment of diseases of the eye. If possible, all evaluation and testing will be completed on your initial visit. Patients should realize that a complete eye exam with or without testing, could last anywhere from one hour to one and a half hours.

First time patients must provide a thorough medical history, including all medications. Enclosed you will find our patient information sheet, patient medical history, consent for dilated exam, financial policy, authorization to disclose PHI (protected health information), medical vs. wellness exam, routine eye care insurance and vision coverage. Please complete **ALL** forms and bring them with you to your office visit.

At your visit, a vision test and measurement of intraocular pressure will be performed, followed by dilation of the pupils with eye drops. Depending on your physician's findings, additional testing may be performed. Routine eye exams require a refraction to be performed.

What you need to bring:

- ❖ Photo ID
- ❖ Eyeglasses
- ❖ Contact lenses with packaging or contact lens prescription
- ❖ Your insurance cards
- ❖ Referral from your primary care physician if your insurance requires it.
- ❖ Past medical records and diagnostic testing from previous eye doctors
- ❖ A list of your current medications
- ❖ A list of your allergies

If you have any further questions, please feel free to contact the office. Thank you.

Sincerely,
The Eye Institute

Mulanet/2017eaw/forms
Patient Letter
2/2017

*******PLEASE READ CAREFULLY*******

FOLLOWING ARE FORMS TO REVIEW AND COMPLETE.

- PATIENT INFORMATION SHEET
- PATIENT MEDICAL HISTORY (2 PAGES)
- ROUTINE EYE CARE: INSURANCE
- FINANCIAL POLICY
- INFORMATION AND CONSENTS
- AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
- NOTICE OF PRIVACY PRACTICES

******KNOW BEFORE YOU GO******

AVOID UNEXPECTED BILLS!

CONTACT YOUR INSURANCE COMPANY

- CONFIRM IF OUR **DOCTORS PARTICIPATE** WITH YOUR INSURANCE AND, MORE IMPORTANTLY, **YOUR SPECIFIC INSURANCE PLAN.**
- ASK IF YOU **NEED A REFERRAL AND OBTAIN ONE, IF REQUIRED.**
- ASK YOUR INSURANCE COMPANY IF YOUR PLAN REQUIRES YOU TO SEE AN **OPHTHALMOLOGIST OR OPTOMETRIST.**
- ASK YOUR INSURANCE COMPANY IF YOU HAVE A **SPECIALIST COPAY.**
- ASK IF YOU HAVE **ROUTINE COVERAGE.**

- **THE ONLY VISION PLAN WE PARTICIPATE WITH IS “VSP” – VISION SERVICE PLAN. WE DO NOT PARTICPATE WITH: DAVIS VISION, UNITED HEALTH CARE VISION, SPECTERA, AETNA VISION, EYEMED, NVA, AMONG OTHERS.**

Mulanet/2017eaw/forms/ptinsinfo

PATIENT INFORMATION SHEET
The Eye Institute
(973) 696-0300

Patient Information:		Date:		Primary Insurance Information		
First Name:		MI:		Insurance Co Name:		
Last Name:		Age:		ID#	Group#	
Date of Birth:		Gender:		Policy Holder Name:		
SS#:		Policy Holder DOB:		Gender:		
Address:		Policy Holder SS#:				
City/St:		Zip:		Relationship to Policy Holder:		
Email:		Cell#:		Policy Holder Address:		
Home#:		Work#		City/St:	Zip:	
Marital Status: M/S/D		Phone#				
Occupation:		Does your Insurance require a REFERRAL ? Y/N				
Employer:		Does your HEALTH Insurance company allow one routine visit per year? Y/N				
Work Address:		Do you have a separate VISION Plan? Y/N				
City/St:		Zip:		Name of Vision Plan: VSP/Davis Vision/Eye Med/Spectra/United Health Care Vision/ Other Plan		
Emergency Contact:		Name _____				
Relationship:		TEI participates with VSP and certain Eyemed Plans				
Phone#		Does your Vision Plan request that you see an optometrist or ophthalmologist Please circle which one				
Referred By:		If yes, one				
Primary Care Physician			Secondary Insurance Information			
Name:			Insurance Co Name:			
Address:		Phone:		ID#	Group#:	
City/St:		Zip:		Policy Holder Name:		
Pharmacy Name:			Policy Holder DOB:		Gender:	
Address:			Policy Holder SS#:			
City/St:		Zip:		Relationship to Policy Holder:		
DUE TO NEW FEDERAL REGULATIONS, WE NEED TO ASK THE FOLLOWING: Race/Ethnicity: African American/ Asian-Pacific Island/Caucasian/ Hispanic/Native American/Other/ Primary Language _____ Patient Refused to Answer...			Policy Holder Address:			
			City/St:		Zip:	
			Employer Name:			
			Address:			
			City/St:		Zip:	
			Phone:			

Patient Signature:		Date:
Parent or Guardian Signature: (if patient is a minor)		
Print Name of Parent or Guardian:		

Patient Medical History

Name: _____ Age: _____ Date: _____

Are you here for a Routine Eye Exam? Yes or No

Are you here for a problem? Yes or No if "yes" what kind of problem?

EYE HISTORY:

YES	NO		YES	NO
___	___	Diabetic Retinopathy	___	___
___	___	Macular Degeneration	___	___
___	___	Cataracts if "yes" did you have surgery? Yes or No	___	___
		which eye? Right or Left		
		When did you have surgery? _____.		
___	___	Eye Laser Surgery- if "yes" when and what type?		
		Right Eye: _____		
		Left Eye: _____		

Do you wear glasses? If "yes" are they for READING DISTANCE BOTH

Do you wear contact lenses? If "yes" BRAND NAME: _____

RIGHT EYE: POWER: _____ BC: _____ DIA: _____

LEFT EYE: POWER: _____ BC: _____ DIA: _____

HOW LONG DO YOU WEAR THEM? DAILY 2 WEEKS MONTHLY OTHER

(PLEASE BRING THE BOXES TO YOUR APPOINTMENT)

PAST MEDICAL HISTORY:

YES	NO		YES	NO
___	___	Diabetes: _____ years	___	___
___	___	High Blood Pressure	___	___
___	___	Asthma	___	___
___	___	Cancer: type _____	___	___
		Other: _____		

Any Major Illness or Injury: _____

Past Surgical History: list type of surgery and dates if possible:

ALLERGIES TO ANY MEDICATIONS: _____ NONE if YES: _____

LIST OF CURRENT MEDICATIONS: _____ NONE INCLUDE ANY EYE DROPS, GLAUCOMA, TEARS, VITAMINS

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

<u>FAMILY HISTORY:</u>	YES	NO	Relationship to pt		YES	NO	Relationship to pt
Cataracts:	___	___	_____	Blindness	___	___	_____
Glaucoma:	___	___	_____	HBP/ Heart	___	___	_____
Macular Degeneration	___	___	_____	Diabetes	___	___	_____
Retinal Detachment	___	___	_____	Cancer	___	___	_____

SOCIAL HISTORY:

Current Occupation: _____

Do you use Tobacco? If yes, how much per day? _____

Alcohol? If yes, how much per day? _____

Street Drugs? If yes, how much per day? _____

Do you have or have you had any sexually transmitted diseases? _____ HIV/AIDS? _____
 _____ liver/ hepatitis

REVIEW OF SYSTEMS:

YES	NO		EXPLANATION OF PROBLEM
___	___	Fever/ Chills/ Weight change	_____
___	___	Hearing or Sinus problems	_____
___	___	Hoarseness/ Difficulty swallowing	_____
___	___	Chest pain/ heart problems/circulatory	_____
___	___	Shortness of breath/ coughing/ lung problems	_____
___	___	Digestive/ intestine problems/ulcer	_____
___	___	Kidney/bladder/ genital problems	_____
___	___	Muscle/joint pain/arthritis	_____
___	___	Skin rashes/sores	_____
___	___	Breast lumps/discharge	_____
___	___	Weakness/numbness/seizures	_____
___	___	Depression/ anxiety/ emotional problems	_____
___	___	Excessive thirst or urination/ hormone problems	_____
___	___	Easy bleeding/ bruising/ anemia	_____
___	___	Swollen glands/ immune system problems	_____
___	___	Hay fever/ allergies	_____
___	___	Neurological problems	_____

Office use only:

History reviewed: _____ No changes _____ Additions as above

Physicians Signature: _____ Date: _____

Patient Name: _____

INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

It is important for your eyes to be dilated for your exam today.

Dilating eye drops are used to enlarge the pupils of your eyes to allow the physician to obtain a better view of the inside of your eyes. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as any eye conditions. Dilation frequently changes the vision for a length of time, which is different for each person. You may be more sensitive to bright lights and driving may be more difficult immediately after the examination. It is not possible for the doctor to predict to what degree your vision will be affected. If you are concerned about any of these problems, you may want to make alternative transportation arrangements, although many do drive after the dilated exam. We suggest you bring your sunglasses to your visit, or we can provide temporary sunglasses if needed.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize the Doctor and or assistants as may be designated by the doctor to administer the dilating eye drops. I understand and acknowledge any potential risks that the dilating drops may have on the ability to drive, and will take appropriate measures to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

I agree to have the dilation examination today.

_____ Date: _____

Patient signature (or person authorized to sign for the patient)

INFORMATION AND CONSENT FOR REFRACTION

We may have to do a REFRACTION at your visit today.

A REFRACTION is a diagnostic test used to determine the patient's best ability to see. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eyes, which is essential medical information for us to have as we assess your eyes and look for any problems.

Refractions are NOT covered by Medicare, and many other health insurance plans.

Our office fee is \$50.00 and unless your insurance plan automatically covers the refractions charges, this will be collected at the time of service in addition to any co-pays that your insurance plan requires. Should your plan pay for the refraction, The Eye Institute will reimburse you accordingly.

I accept full responsibility for the cost of this service.

_____ Date: _____

Patient signature (or person authorized to sign for patient)

INFORMATION AND CONSENT FOR CONTACT LENS EVALUATION

In order to update or change your prescription for contact lenses, we will need to perform a contact lens evaluation. This evaluation involves checking vision with current lenses and presenting a series of alternate lenses to determine which prescription provides the sharpest and clearest vision. It also involves an evaluation of the fit and centration of the lenses by the physician using the microscope. This testing is needed to ensure that the lenses are not adversely affecting your eyes.

Our office fee for a contact lens evaluation is \$45. This fee is collected in addition to any co-payments, coinsurance or deductible payments at the time of service. I accept full responsibility for the cost of this service.

_____ Date: _____

Patient Signature (or person authorized to sign for the patient)

ROUTINE EYE CARE: INSURANCE

Your appointment today includes an eye examination. For your continued ocular health, it is recommended that you have a complete exam once a year including dilation, measuring intra-ocular pressure and a refraction.

Refractions are done during eye exams to determine the visual acuity of the eyes. This test is performed to see if the patient requires glasses or a change in their glasses prescription. This test can also determine underlying medical issues. **Some insurance companies cover refractions and some do not, such as MEDICARE.**

If you are having **any problems** concerning your eyes, it is **essential to tell the doctor and staff prior to the completion of your visit.**

It is imperative to understand that the “**diagnosis code**” or “**procedure code**” cannot be improperly **altered for the purpose of getting the exam covered**. Fortunately, some insurance companies do cover Routine Eye Exams.

As medical records cannot be altered at a later time, chronic on-going conditions will be addressed and coded appropriately.

It is important that you are aware of your financial responsibility for your visits, particularly if your insurance does not cover preventive care. It is, of course, very **important for you to understand your own insurance coverage.**

I have read and understand the information above.

Signature _____ Date _____

THE EYE INSTITUTE FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your assistance and understanding of our payment policy is necessary, as all financial liability ultimately rests with the patient. Please ask if you have any questions about our fees, financial policy or your financial responsibilities. patients must fill out patient information and financial forms prior to seeing the doctor.

Self-pay patients are required to make full payment up front at the time of your visit.

- **CO-PAYMENTS**—By law we MUST collect your carrier-designated copay at the time of service. Please be prepared to pay your CoPay at each visit.
- **HMO AND MANAGED CARE PLANS**—COPAYMENTS are due at the time of your appointment. Patients are responsible to pay ANNUAL DEDUCTIBLE AND COINSURANCE, if applied by your insurance policy. If a • **REFERRAL** is required from your primary care physician, it is your responsibility to obtain it prior to your appointment. **If you do not have your referral, you will need to reschedule your appointment.** Your type of insurance does not allow us to make any exceptions.
- **MEDICARE**—Our office will submit a claim to Medicare for your office visit. You will be responsible for 20% coinsurance and applicable deductible, which can be billed to a secondary insurance, if you have one. Please note that the refraction is a non-covered service, according to Medicare regulations. For any questions about the non-covered refraction, please call Medicare.
- **NON-PARTICIPATING INSURANCE AND UNINSURED PATIENTS**—Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.
- **REFRACTIONS**—Medicare and many other medical insurance plans do not cover the refraction fee. Payment for refractions are expected at the time of service. Our fee for the refraction is \$50.
- **CONTACT LENSES**--Payment is expected at the time an order is placed or when it is picked up.
- **RETURNED CHECKS**—Any check payments that do not clear the bank will be subject to a \$45.00 returned check fee.
- **CANCELLATION POLICY**—We require **24 hours notice** for an appointment cancellation, otherwise, we reserve the right to charge a \$75 cancellation fee.
- **WORKERS COMPENSATION**--You are responsible for promptly submitting our bill to your employer. You will be responsible for any bills not paid in full within thirty (30) days.
- **MOTOR VEHICLE ACCIDENT**—It is your responsibility to submit bills to your auto insurance company. You are responsible for any deductibles or copayments. You will be responsible for any bills that are not paid in full within thirty (30) days.
- **SURGERY**—Our physician fees for surgery and hospital visits will be billed directly to your insurance company. You are responsible for any non-covered fees. Our fees do not include charges for the surgi-center or hospital-dispensed medications, or another physician's fees.
- **RESPONSIBLE PARENT**—In the case of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for the full payment of out-of-pocket fees at the time of service.

I instruct and direct Medicare and/or my insurance company(s) make payment on my behalf to The Eye Institute for any services provided by them to me or my dependents for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I HAVE AGREED TO PAY ANY BALANCE OF PROFESSIONAL SERVICES CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT. I authorize any holder of medical

information about me to release, in writing, electronically or verbally over the telephone, to my Insurance Company, its agents or any other carrier I may have, and to request any information needed to determine these benefits or the benefits payable for related services on my behalf. I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges for professional services rendered to me, or my dependents. I agree to also reimburse The Eye Institute for any attorney's fees, legal and other costs incurred in collecting any balance that I owe. I hereby authorize The Eye Institute to initiate an appeal to my insurance company, or their agents on my behalf. I hereby authorize The Eye Institute to initiate a complaint to the Insurance Commissioner of any state for any reason on my behalf.

Responsible Party Signature

Print Name

Date

mulanet/2017eaw/forms/financialpolicy

THE EYE INSTITUTE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE: _____

ADDRESS: _____

HOME PHONE: _____ BIRTH DATE: _____

With this consent, The Eye Institute may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to the The Eye Institute's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Eye Institute reserves the right to revise its notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by a written request to The Eye Institute's Privacy Officer, 968 Hamburg Turnpike, Wayne NJ 07470.

This consent authorizes The Eye Institute to call, e-mail or mail to my home or other designated location and leave messages in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results, among others.

This consent authorizes The Eye Institute to email or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and free health resources and periodic special offers from our offices. The Eye Institute may also leave messages on my voicemail.

By signing this form, I am consenting to The Eye Institute's use and disclosure of my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Eye Institute may decline to provide treatment to me.

DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for a relative or a friend to contact our office to inquire about your PHI. These individuals may include your spouse, children, relatives, roommates, domestic partners or other associates.

I authorize The Eye Institute's staff and physicians to disclose any PHI pertaining to my TPO to the individuals named below:

Name of Person	Relationship to Patient:	Phone
1. _____		
2. _____		

None:

Date: _____

Name of Patient (print)

Parent/Legal Guardian Name (print) Signature of Patient or Legal Guardian

Cell Phone _____ Email _____

Notice of Privacy Practices

Eye Associates of Wayne, P.A.

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information.

Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices – We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice and if such is maintained by the practice on its web site.

You have the right to authorize other use and disclosure – This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes or if we intended to sell you PHI. You may revoke an authorization at any time, in writing, except to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone) and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information. This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

If you have questions regarding your privacy right, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclose of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment – We may use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices – We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities or with respect to a group health plan to disclose information to the health plan sponsor. You will have the right to opt out of such special notices and each such notice will include instructions for opting out.

Payment – Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations – We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization – The practice may elect to use a health information organization, or another such organization to facilitate the electronic exchange of information for the purposes of treatment, payment or healthcare operations

To Others involved in your Healthcare – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures – We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; workers compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us or directly to the Secretary of the Department 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 the Privacy Manager at:

Eye Associates of Wayne, P.S. 968 Hamburg Tpke, Wayne, NJ 07470

We will not retaliate against you for filing a complaint.