



EYE CENTERS OF NORTH TEXAS, PLLC (RETINA OF NORTH TEXAS)

NOTICE OF PRIVACY PRACTICES

Effective Date: June 2026

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.

WHO WILL FOLLOW THIS NOTICE

We may use your medical information for treatment, payment, healthcare operations, research or fundraising purposes as described in this notice. All employees of Eye Centers of North Texas, PLLC (Retina of North Texas) (the “Practice” or “Facility”) and workforce members of Eye Centers of North Texas, PLLC affiliates follow these privacy practices. The physicians on our medical staff will also follow this notice.

ABOUT THIS NOTICE

This notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and our obligations regarding the use and disclosure of medical information.



We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to your medical information;
- follow the terms of the notice that is currently in effect; and
- notify individuals, either known or reasonably believed to be affected, following a breach of unsecured protected health information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and give examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one or more of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other Practice or Facility personnel who are involved in your care. Different departments of the Practice or Facility also may share medical information about you in order to coordinate the



different services you may need, such as prescriptions, lab work and imaging services. We also may disclose medical information about you to people outside the Practice or Facility who may be involved in your medical care.

- For Payment. We may use and disclose medical information about you so that we may bill for treatment and services you receive at the Practice or Facility and collect payment from you, an insurance company, or another party. For example, we may need to give information about the medical care you received at the Practice or Facility to your health plan so that the plan will pay us or reimburse you for the applicable treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to other healthcare facilities for purposes of payment as permitted by law.
- For Healthcare Operations. We may use and disclose medical information about you for operations of the Practice or Facility. These uses and disclosures are necessary to run the Practice or Facility and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the Practice or Facility should offer, what services are not



needed and whether certain new treatments are effective. We may also combine medical information we have with medical information from other Practice or Facility to compare our performance and to make improvements in the care and services we offer. We may also disclose information to doctors, nurses, technicians, medical students and other Practice or Facility personnel for educational purposes. We may also disclose information about you to other healthcare facilities as permitted by law.

- Appointment Reminders. We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care.
- Treatment Alternatives. We may use and disclose medical information to tell you about possible treatment options that may be of interest to you.
- Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your



family can be notified about your condition, status, and location.

- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information to balance research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will be approved through this process. However, we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Practice or Facility. When required by law, we will ask for your specific written authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at the Practice or Facility.
- As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law.



- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Fundraising. We may use your information to contact you in connection with fundraising efforts. However, we will provide you with the opportunity to opt out of receiving fundraising communications.

SPECIAL SITUATIONS

- Special privacy protections apply to HIV- related information, alcohol and substance abuse information, mental health information and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided an explanation of how the information will be protected. For further information, please contact the Privacy Officer. This contact information is listed on the last page of this Notice.
- Organ and Tissue Donation. If you are an organ or tissue donor, we may release medical information about you to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.
- Military and Veterans. If you are a member of the armed forces of the United States or another country,



we may release medical information about you as required by military command authorities.

- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.
- Public Health Risks. We may disclose to authorized public health or government officials medical information about you for public health activities.

These activities generally include the following:

- to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or service;
- to prevent or control disease, injury, or disability;
 - to report disease or injury;
- to report births and deaths; ○ to report child abuse or neglect; ○ to report reactions to medications and food or problems with products;
- to notify people of recalls or replacements of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.



- Law Enforcement. We may release medical information about you if asked to do so by a law enforcement official:
 - o in response to a court order, subpoena, warrant, summons or similar process;
 - o to identify or locate a suspect, fugitive, material witness or missing person;
 - o about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement;
 - o about a death we believe may be the result of criminal conduct;
 - o about criminal conduct at the Practice or Facility or by healthcare providers affiliated with the Practice or Facility;
 - o in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; and to authorized federal officials so they may provide protection for the President and other authorized persons or conduct special investigations.
- Coroners, Medical Examiners and Funeral Directors. We may release medical information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information to funeral directors so they can carry out their duties.



- National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- • To a School. We may disclose information to a school, about an individual who is a student or prospective student of the school, if:
 - o The protected health information that is disclosed is limited to proof of immunization;
 - o The school is required by State or other law to have such proof of immunization prior to admitting the individual; and
 - o The covered entity obtains and documents the agreement to the disclosure from either:
 - A parent, guardian, or other person acting in loco parentis of the
 - individual, if the individual is an unemancipated minor; or
 - The individual, if the individual is an adult or emancipated minor.
- Other Uses and Disclosures. Other uses and disclosures not
- described in this Notice will be made only with your written authorization, and you may revoke such authorization provided under this section at any time, provided that the revocation is in writing, except to the



extent that we have taken action(s) in reliance upon your authorization; or if the authorization was obtained as a condition of obtaining insurance coverage.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- You have the following rights regarding medical information we maintain about you:
- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. This right does not include psychotherapy notes, information compiled for use in a legal proceeding or certain information maintained by laboratories. In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed on the last page of this Notice for the location at which you were treated. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed. To request a review, contact the Privacy Office. This contact information is listed on the last page of this



Notice. A licensed healthcare professional will conduct the review. We will comply with the outcome of the review.

- Right to Amend. If you think that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice or Facility. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, listed on the last page of this Notice, for the location at which you were treated. In addition, you must give a reason that supports your request. We
- may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - o was not created by us, unless the person or entity that created the information is no longer available to make the amendment; o is not part of the medical information kept by or for the
 - Practice or Facility;
 - o is not part of the information that you would be permitted to inspect and copy; or is accurate and complete.

We will provide you with written notice of action we take in response to your request for an amendment.



- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment or healthcare operations or made pursuant to an authorization signed by you. To request an accounting of disclosures, you must submit your request in writing to the Privacy Office. This contact information is listed on the last page of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will attempt to honor your request. If you request more than one accounting in any 12-month period, we may charge you for our reasonable retrieval, list preparation and mailing costs for the second and subsequent requests. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. Additionally, you



can request restrictions on medical information disclosed 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 the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full. To request a restriction, you must contact the Privacy Office. This contact information is listed on the last page of this Notice.

- We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. You may terminate the restriction at any time. If we terminate the restriction, we will notify you of the termination. We are not able to terminate or refuse your request for restrictions to disclosures to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a



written request to the Privacy Office. This contact information is listed on the last page of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at your first treatment encounter at the Practice or Facility. You may get an additional copy of this Notice at any time by contacting the Privacy Office. This contact information is listed on the last page of this Notice.

CHANGES TO THIS NOTICE

- We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we receive in the future. We will post copies of the current Notice at the Practice or Facility. The Notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register at the Practice or Facility for treatment or healthcare services, we will provide available copies of the current Notice. Any revisions to our Notice will also be posted on our website.

OTHER USES OF MEDICAL INFORMATION



- Other uses and disclosures of medical information not described in this Notice or the laws that apply to us will be made only with your written authorization on a Practice or Facility authorization form. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we may continue to use or disclose that information to the extent we have relied on your authorization. You also understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FOR FURTHER INFORMATION OR COMPLAINTS

If you have a question or wish to file a complaint related to the privacy of your health care information, please email us at info@retinanorthtexas.com.

If you wish to remain anonymous, contact the Compliance Hotline via telephone at (800) 411-3588.

Additionally, you may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services located at:

200 Independent Avenue, SW Washington, DC 20201
OCRCComplaint@hhs.gov





NOTICE OF FINANCIAL POLICY

Please read and sign the following financial policy summary prior to your first office visit. If you have questions about this Financial Policy, please contact our office at 214-233-6170. **The policy applies to all office visits, procedures, and surgeries.**

1. Payment is due in full at the time services are rendered. We accept cash, check, and all major credit cards. Post-dated checks will not be accepted by our office.
2. Please be prepared to provide our office with a copy of your insurance card(s) and picture identification every time you visit our practice. Each time you visit our office you may be required to update your personal information such as home address, contact phone numbers, and emergency contact phone numbers. If there are any changes in your insurance, it is your responsibility to notify our office prior to your visit. If the new insurance information is not provided prior to the visit, you could be responsible for charges incurred for any dates of service or treatments prior to the new information being given.
3. If your insurance requires you to pay a co-pay, then you must pay this co-pay at the time of your appointment. Your visit or treatment may be rescheduled if prior authorization from insurance or PCP is required. Payment of unauthorized services is then your responsibility. Fees not covered by your insurance company due to unmet



deductibles are due as you leave the office. If this should be the case, we offer payment plans to ensure your treatment does not go unfinished. By signing below, you authorize Eye Centers of North Texas PLLC and its staff to release medical information necessary for the processing of my insurance claims, billing, and other related healthcare services. You acknowledge that Eye Centers of North Texas PLLC has the right to bill claims directly to my insurance company, and that your insurance company has the right to issue payment directly to Eye Centers of North Texas PLLC for services rendered

4. Physician surgical fees owed are due prior to any surgery performed by the doctor(s) in the various facilities we perform surgery in. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the surgeon only. The facility where the operation is performed is responsible for quoting and collecting payment for their fees. It is your responsibility to contact the surgery facility to obtain their fees and make payment arrangement prior to the date of surgery.
5. Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.
6. Any PAST DUE BALANCE is required to be paid either by the statement received from our billing office or at the time of your next visit. In the event your account is past due, we will take the necessary steps to collect the debt,



and possible referral to a collection agency which could affect your credit record.

7. SELF PAY/CASH PAY POLICY: For patients who are using cash for their office visit, a \$300 deposit MAY be due at the time of service. This is a discounted rate for a new visit which included a dilated fundus ophthalmoscopy and a basic diagnostic optical coherence tomography.
8. INSURED PATIENTS WITH UNMET DEDUCTIBLE: For patients who have not met their insurance deductible, a \$300 deposit MAY be due at the time of service. This deposit will be applied to the actual charges for the visit. If the visit charges exceed \$300, the remaining balance will be billed to you. In the event the actual charges are less than \$300, the difference will be refunded within 14 days from the last insurance payment.
9. A \$25.00 return check fee will be assessed if your check is returned by your bank.
10. Due to the amount of support services associated with FMLA or disability paperwork, we may charge \$25.00 for its completion.

Left blank intentionally



PATIENT ACKNOWLEDGEMENT

AUTHORIZATION FOR CARE

I grant permission for Eye Centers of North Texas PLLC-Retina of North Texas to render such care that my provider may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment, digital imagery, diagnostic testing and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Eye Centers of North Texas PLLC-Retina of North Texas to release necessary information for the following reasons: to other providers for continuing professional care; to any insurance company or third-party payer for the purpose of processing a claim; to be contacted regarding care or otherwise as allowed by law. I release Eye Centers of North Texas PLLC-Retina of North Texas from any liability for the release of this information.

HIPAA NOTICE OF PRIVACY PRACTICES

Eye Centers of North Texas PLLC-Retina of North Texas is required by applicable federal and state law to maintain the privacy of your protected health information. “Protected Health Information” (PHI) is information about you, including demographic information, that may identify you and that release to your past, present or future physical or mental health condition and related health care services. We are



required to give you notice about our privacy practices and your rights concerning your PHI. By initialing this box, you acknowledge that you have been given or offered the “Notice of Privacy Practices” of Eye Centers of North Texas PLLC-Retina of North Texas.

SECURE MESSAGING AND ELECTRONIC COMMUNICATION

Eye Centers of North Texas PLLC-Retina of North Texas has the ability to correspond with patients and providers electronically through a secure messaging portal. I hereby authorize Eye Centers of North Texas PLLC-Retina of North Texas to electronically communicate via email and/or text message, when applicable regarding my healthcare. I understand that email and text communications may not be appropriate for urgent medical concerns, and I should call the office or seek emergency care for urgent or emergency symptoms.

HIPAA ACCESS FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Eye Centers of North Texas PLLC-Retina of North Texas is to restrict access to my Protected Health Information. In addition to other providers providing health services, and my insurance company(-ies) for payment of my claim, I will provide verbal or electronic/written authorization for any person(s) to have access to my Private Health Information.

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**EYE CENTERS OF NORTH TEXAS, PLLC
RETINA OF NORTH TEXAS**

PATIENT POLICY SIGNATURE PAGE

Patient Chart Number: _____

I ACKNOWLEDGE THAT I HAVE REVIEWED, UNDERSTAND, AND ACCEPT THE **PATIENT ACKNOWLEDGEMENT AND COMMUNICATION CONSENT, FINANCIAL POLICY, AND PRIVACY PRACTICES POLICY** OF THE EYE CENTERS OF NORTH TEXAS, PLLC DOING BUSINESS AS RETINA OF NORTH TEXAS. ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

Patient/Legal Guardian Printed Name

Date of Birth

Patient/Legal Guardian Signature

Today's Date