Eyes4Kids
ROBERTO WARMAN, M.D.

SERVICES NOT COVERED BY INSURANCE

To all Our Patients

As you know, we are committed to providing you the very best eye care available. Unfortunately, some health insurance companies do not always cover all the services that may be provided during your child's eye examination. **Routine Eye Exams and Refractions** are often not covered as a result, we may have to charge for these services, separate from any co-payment you might have.

What is a Routine Eye Exam?

A routine eye examination is an exam to make sure your child's eyes are healthy but your child is not experiencing any particular problems with the eyes. If your child complains about blurry vision, pain in and around eyes, itchy red eyes, or some other problems please make sure you let us know, because your visit may be covered by your insurance company. However, if your child simply needs to get eyeglasses or contact lenses most insurance companies will **not** cover the eye exam. Unfortunately, these rules and restrictions are set by your insurance company and we must abide by them.

What is Refraction?

Refraction is an exam that is done to determine whether a child is nearsighted, farsighted, has astigmatism, and whether glasses are necessary or need to be changed. This is an essential part of any eye examination and it is very important for children of all ages from infancy to adult; it identifies problems such as amblyopia (also known as lazy eye) and strabismus (also known as crossed eye) as well as helping determine why your child might have failed a vision screening at school or at the pediatrician or family practitioner's office. The refraction is critical in **helping determine precisely how well your child can see.** If your child's vision cannot be corrected with glasses, they might have some other eye disease, and a refraction is the only way we can effectively determine this. Unfortunately most medical insurances will not pay for a refraction, although it is a fundamental part of a comprehensive eye examination. With that being said, please make sure you review your insurance policy carefully as some companies may provide reimbursement for this service. However, either way, you will have to pay for this service on the day of your child's exam.

Thanks for trusting your child's eye care needs with us.

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PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician (s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician (s) by the insured or his/her family.

RELEASE OF INFORMATION: The physician (s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician (s) or to the patient or to a family member or employer of the patient for all or part of the physician (s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

H.M.O DISCLAIMER: I certify that I AM OR I AM NOT presently enrolled in any Health Maintenance organization (H.M.O). Subsequent rejection of a claim as a result of this admission, due to current enrollment in a H.M.O Plan will constitute responsibility for payment of claim on my part.

COLLECTION POLICY: I agree that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney fees and court costs.

LIFETIME AUTHORIZATION

MEDICARE AND MEDICAID PATIENT CERTIFICATION- PATIENT CERTIFICATION AUTHORIZATION TO REALEASE INFORMATION AND PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician (s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

_____ _____

Date Witness

_____ _____

Print Patient's Name Patient's Signature/Person Responsible

Patient unable to sign due to: _____

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MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** your child currently takes (prescription and over-the counter):_____

_____

Does your child have new allergies to any medications, since your last visit? **YES** **NO**
If YES, list the medications: _____
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____
List any surgeries your child has had (cataract, tonsillectomy, appendectomy):
_____

Does your child ***currently*** have any problems in the following areas?:			
If YES, please provide information.	**YES**	**NO**	**Details**
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			

GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
(continued) If YES, please provide information.	**YES**	**NO**	**Details**
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia**)**			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY M = mother F = father S = sibling GP = grandparent

Disease	**YES**	**NO**	**Relationship to Patient**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital status (married, divorced, single, widowed): _____

Living arrangements: _____

Does your child drive? **YES** **NO**

Does your child have visual difficulty when driving? **YES** **NO**

Does your child have problems with night vision? **YES** **NO**

Have you ever tried to wear contact lenses? **YES** **NO**

Does your child currently wear contact lenses? **YES** **NO** If YES, how long? _____

Does your child currently wear glasses? **YES** **NO** If YES, how long have you had your current prescription? _____

Does your child drink alcohol? **YES** **NO** If YES: occasional 1/day 2-3/day 4+/day

Does your child smoke? **YES** **NO** If YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Physician's Signature: _____ *Date:* _____

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PATIENT AGREEMENT FOR EMAIL COMUNICATIONS

Communications over the internet and /or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form.

Please be advised that:

This request applies to the office Pediatric Ophthalmology Consultants including Pediatric Plus Optical DBA OPTIWOW or with Dr Roberto Warman, eyes4kids or optiwow.com

Pediatric Ophthalmology Consultants will not communicate health information that is specially protected under state and federal law (for example HIV/AIDS information, substance abuse treatment, mental health information) via email even if we agree to communicate with you via email.

Please provide us the email address to which communication should be addressed to

_____

Please initial each phrase:

____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____I understand and acknowledge that communications over the internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

____I understand that email communication in which I engage may be forwarded to other providers, including providers not associated with Pediatric Ophthalmology Consultants, for purposes of providing treatment to me or my child.

____ I agree to hold Pediatric Ophthalmology Consultants, Pediatric Plus Optical and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

_____ _____

Signature of Patient or Legal Representative Date

_____

Name of Patient or Legal Representative

Eyes4Kids
ROBERTO WARMAN, M.D.
Located inside
Nicklaus Children's Hospital
3200 S.W 60 Court. Ste 103
Miami, Florida 33155-4072
www.eyes4kids.com

Patient Information

Today's Date:_____

Patient Name:_____
Last First Middle

Date of Birth:_____ Sex: ❒ Male ❒ Female
Month Day Year

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Race: ❒ African ❒ Caucasian ❒ Hispanic ❒ Other_____

Preferred Language: ❒ English ❒ Spanish ❒ Creole ❒ Other_____

Email:_____

Referring Physician_____ Phone#_____

Primary Care Physician/Pediatrician_____ Phone#_____

Pharmacy_____ Address#_____

Parent(s)/Legal Guardian Information

Who has legal custody of the patient:

❒ Parents ❒ Mother Only ❒ Father Only ❒ Foster Parent ❒ Grandparent ❒ HR ❒ Other_____

Mothers Name_____ D.O.B. _____ SS#_____

Address ❒ Check if same as above

_____ City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Employer_____ Employer Address_____

Fathers Name_____ D.O.B. _____ SS#_____

Address ❒ Check if same as above

_____ City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Employer_____ Employer Address_____

Emergency Contacts

1. Name_____ Relationship_____ Phone_____

2. Name_____ Relationship_____ Phone_____

Insurance Information

1. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

2. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit, you will be responsible for any payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient or Parent/Guardian Signature_____

Patient Name_____ Date_____

Emergency Contacts

1. Name_____ Relationship_____ Phone_____

2. Name_____ Relationship_____ Phone_____

Insurance Information

1. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

2. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit, you will be responsible for any payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient or Parent/Guardian Signature_____

Patient Name_____ Date_____

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RECORD RELEASE AUTHORIZATION

I hereby authorize and request you to release to:

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

The records in your possession, concerning my child's illness and/or treatment during the following period

From: _____ To: _____

Patient Name: _____

Patients Date of Birth: _____

Address: _____

_____

Signature of Parent/Guardian: _____

Name of Parent/Guardian: _____

Date: _____

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.

If you have any questions about this Notice please contact our Privacy Officer who is Ivonne Goldstein

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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.

Health Care 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, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. 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 protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 health care 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 your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

3. 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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Ivonne Goldstein** at (305) 662-8390 **igoldstein@eyes4kids.com** for further information about the complaint process.

This notice was published and becomes effective on **May 23, 2012.**

Discrimination is Against the Law

Roberto Warman M.D. & Associates, P.A. dba Pediatric Ophthalmology Consultants ("Pediatric Ophthalmology Consultants") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pediatric Ophthalmology Consultants does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pediatric Ophthalmology Consultants:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact Ivonne Goldstein.

If you believe that Pediatric Ophthalmology Consultants has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: administrator Ivonne Goldstein, 3200 SW 60t Ct, Ste 103, Miami, FL 33155, Tel - (305) 662-8390, Fax – (305) 661-7862, igoldstein@eyes4kids.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pediatric Ophthalmology Consultants is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(305) 662-8390.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-(305) 662-8390.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-(305) 662-8390.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-(305) 662-8390.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(305) 662-8390.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-(305) 662-8390.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-(305) 662-8390.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-(305) 662-8390.

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-(305) 662-8390

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-(305) 662-8390

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-(305) 662-8390

Korean: □□: □□□□ □□□□□ □□, □□ □□ □□□□ □□□ □□□□ □ □□□□. 1-(305) 662-8390.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-(305) 662-8390.

Gujarati: □□□□□: □□ □□□ □□□□□□□ □□□□□ □□, □□ □□:□□□□□ □□□□ □□□□ □□□□□ □□□□□ □□□□ □□□□□□ □□. □□□ □□□ 1-(305) 662-8390.

Thai: □□□□□: □□ □□□ 1-(305) 662-8390