VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
NOTICE OF PRIVACY PRACTICES

Effective March 2013

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.
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.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Exercising Your Rights: You may exercise any of your below rights by visiting the Patient Rights page or completing the Member Complaint/Grievance Form located on vsp.com, or calling Member Services at **800.877.7195**.

Patient Rights	• Access: You can ask to see or get a copy of your health and claims records and other health information we have about you. • Amend: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. • Confidential communication: You can ask us to send your protected health information directly to you at an alternative address. • Restrict: You can ask us not to use or share certain health information for treatment, payment (no cost to patient claims processing), or our operations. • Accounting of Disclosures: You can ask for a list of the times we've shared your health information. • Appointment of Representative: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • Complain: You can complain if you feel we have violated your rights by submitting a written complaint to us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877.696.6775, or visiting hhs.gov to file an online complaint. We will not retaliate against you for filing a complaint. • Notice: You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. • If you are not able to tell us your preference, we may share your information when needed to lessen a serious and imminent threat to health or safety. • VSP never shares sells your information or shares it for marketing purposes unless you give us written permission.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Use and Disclose for treatment, payment, and healthcare operations.	• Treatment: We can use your health information and share it with professionals who are treating you. • Payment: Eyes of Hope/Mobile Clinics submits no cost to patient claims to help us track and improve healthcare services and for auditing purposes. • Healthcare Operations: We can use and disclose your information to run our organization and contact you when necessary.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as for public health and research purposes, but also to respond to lawsuits and legal actions. We have to meet many conditions in the law before we can share your information for these purposes. For more information visit hhs.gov > HIPAA – Health Information Privacy Your Rights under HIPAA.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- Breach Notification: We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- Right to Revoke: If you tell us we can share your information other than as described in this Notice, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information, visit hhs.gov see Department of Health & Human Services Notice of Privacy Practices.

SPECIAL NOTES

- VSP does not collect genetic information and is prohibited from using or disclosing genetic information for underwriting purposes.
- VSP does not use protected health information for research purposes.
- VSP does not collect substance abuse treatment records and will never share any substance abuse treatment records without your written permission.
- VSP will abide by more stringent state and federal laws where applicable.
- Nondiscrimination Statement: VSP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Notice Revisions: We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, on our website, and we will notify you by mail or email.

CONTACT INFORMATION

VSP Global, Attention: Privacy Specialist, 3333 Quality Drive, MS-163, Rancho Cordova CA 95670, 916.858.7432, HIPAA@vsp.com

Classification: Public

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The VSP Eyes of Hope Mobile Clinics Program Notice of Privacy Practices ("Notice") provides information about how Vision Service Plan ("VSP") may collect, use and disclose patient health information. I, the patient (or the parent or legal guardian of the patient), acknowledge that I have the right to review the Notice prior to signing this Consent Form. I acknowledge receipt and review of the Notice by signing below. If the patient is my child or a person for whom I am a legal guardian, references to "I", "me", "my" or similar terms, includes reference to my child or person for whom I am a legal guardian.

By signing below, I acknowledge receipt of the Notice from VSP Global through the Eyes of Hope Mobile Clinics Program. The Notice provides information about how VSP Global may use and disclose my protected health information. I understand that the Notice is subject to change. If the Notice is changed, I may obtain a revised copy by visiting **vspeyesofhope.com**, calling **866.549.9301**, or sending an e-mail to **mobileclinic@vsp.com**.

Signature of Patient OR Parent/Guardian _____

Print Patient Name _____

Print Parent/Guardian Name _____

Relationship to Patient _____

Date ____/____/____

FOR VSP USE ONLY: WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

☐ Notice of Privacy Practices Given – Patient Unable to Sign

☐ Notice of Privacy Practices Given – Patient Declined to Sign

☐ Notice of Privacy Practices and Acknowledgment Mailed to Patient

☐ Other Reason Patient Did Not Sign _____

Signature of VSP Representative _____

Print Legal Name _____

Date ____/____/____

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
GENERAL CONSENT FOR CARE AND TREATMENT

READ THIS DOCUMENT CAREFULLY BEFORE SIGNING*. THIS DOCUMENT HAS LEGAL CONSEQUENCES AND WILL AFFECT YOUR LEGAL RIGHTS AND WILL LIMIT OR ELIMINATE YOUR ABILITY TO BRING FUTURE LEGAL ACTIONS.

By signing this form, I hereby consent to receive a comprehensive OR intermediate eye exam, and, if prescribed, lens and frame services through the VSP Eyes of Hope Mobile Clinics Program.

By signing this form, I also hereby authorize and voluntarily consent to VSP's collection, use and disclosure of my patient health information for treatment, payment**, and health care operational purposes. This includes, but is not limited to, disclosure to and use by third-party medical care providers to whom I may be referred or with whom VSP or I may consult regarding my health. I understand that there is no expiration for this health information authorization and consent, that I have the right to revoke this authorization and consent, unless action has been taken in reliance on it.

I certify that I am of legal age and that I have read and understand this form, and that this form has been voluntarily executed on the date indicated below.

Signature of Patient OR Parent/Guardian _____

Print Patient Legal Name _____

Print Parent/Guardian Name _____

Relationship to Patient _____

Date ____/____/____

*Language Assistance: If you speak another language, language assistance services, free of charge, are available to you. Call 1.800.877.7195 (TTY: 1.800.428.4833) or visit globaleyesofhope.com.

**All services provided to you today through the VSP Eyes of Hope mobile clinic at no cost to you.

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
NONDISCRIMINATION NOTICE & INTERPRETER SERVICES

VSP complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability. VSP does not exclude people or treat them differently because of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability.

VSP provides, free of charge:

- Aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
  - Translators
  - Information written in other languages

If you need any of these services, or believe VSP has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can submit your grievance:

To contact VSP to request aids and services:		
U.S. Mail: VSP, Attn: Complaint & Grievance Unit PO Box 997100 Sacramento CA 95899-7100	Online: vsp.com > Member Grievance Form	Telephone: 800.877.7195 Monday - Friday 5 a.m. to 8 p.m., Pacific Time Saturday 7 a.m. to 8 p.m., Pacific Time Sunday 7 a.m. to 8 p.m., Pacific Time Closed: Major Holidays Hearing impaired: 800.428.4833
To file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:		
U.S. Mail: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html	Online Office for Civil Rights Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf	Telephone: 1–800–868–1019 Hearing impaired: 800–537–7697

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
MEDIA RELEASE AUTHORIZATION FORM

I, the undersigned, authorize Vision Service Plan, dba VSP Global ("VSP"), and all its lines of business, subsidiaries and affiliates, as well as its/their directors, officers, employees, agents, representatives and/or contractors to release and discuss my protected health information (or information regarding the treatment, medical condition, or related topics, of my child or an individual to whom I provide guardianship).

This Authorization includes unlimited right and permission to use, reuse, distribute, publish, and republish, in whole or part, my and/or their testimonial(s), statement(s), and/or image(s) and information related to the diagnosis, treatment and healthcare services provided or to be provided, and which identifies my and/or their name and other personally identifiable information in any electronic, broadcast, printed and/or other form of medium, including all websites, blog and social media platforms maintained, operated by and/or affiliated with VSP in conjunction with its business related publicity and/or media relations activities.

Note: This Authorization excludes any information related to substance abuse, mental health, or diagnosis/treatment of HIV.

- I understand any protected health information, other information, or image(s) released, including via a social media platform, may no longer be protected by applicable federal and state privacy laws.
- I agree to waive all right to inspect and/or approve the finished product(s), copy(ies) and/or printed matter that may be used in connection herewith/therewith, and/or the use to which it may be applied.
- I understand VSP may receive direct or indirect financial remuneration in connection with the use or disclosure of my information/images from a third party due to marketing.
- I understand I will not receive any financial compensation for the use and disclosure of my information/image.
- I understand I have the right to revoke this Authorization up until a reasonable time before my information/image is used by providing written notice to VSP.
- I understand if I revoke this Authorization, my information may no longer be used or released for the reasons covered by this Authorization. However, I understand that any disclosure or publication made prior to a revocation may remain in public domain.
- I understand I have a right to request a copy of this Authorization.
- I understand the information released will be current as of the time this Authorization is signed and that, if additional information is needed at a later date, I may be asked to sign another Authorization.
- I understand signing this Authorization is voluntary and that VSP cannot condition treatment, payment, enrollment, or eligibility for benefits if I choose not to sign this Authorization.
- I release and agree to indemnify and hold harmless VSP from any and all liability, including, but not limited to, claims for libel and right to privacy, in connection with this matter.
- I understand this Authorization is intended as the complete agreement as to and on this subject matter.

I do hereby certify that I am of legal age, have read and understand this Authorization, and acknowledge that this Authorization has been voluntarily executed.

Signature of Patient OR Parent/Guardian _____ **Date** _____/_____/_____

Print Patient Legal Name _____

Patient's Address	**Patient's Phone Number**	**Patient's Email**

Print Parent/Guardian Name _____ **Relationship to Patient** _____

☐ Patient Declines to Authorize

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-877-7195 (TTY: 1-800-428-4833).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-877-7195 (TTY: 1-800-428-4833).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-877-7195 (TTY: 1-800-428-4833).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-877-7195 (TTY:1-800-428-4833)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-877-7195 (TTY: 1-800-428-4833))번으로 전화해 주십시오.

繁體中(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1-800-877-7195 (TTY: 1-800-428-4833).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-877-7195 (телетайп: 1-800-428-4833).

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-877-7195 (TTY (հեռատիպ)՝ 1-800-428-4833).

فارسی(Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-877-7195 (TTY:1-800-428-4833) تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-877-7195 (TTY: 1-800-428-4833) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau 1-800-877-7195 (TTY: 1-800-428-4833).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-877-7195 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم **1-800-877-7195** (رقم هاتف الصم والبكم: **1-800-428-4833**)

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-877-7195 (TTY: 1-800-428-4833) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-877-7195 (TTY: 1-800-428-4833).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-877-7195 (TTY: 1-800-428-4833)។

ພາສາລາວ (Lao)
ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-877-7195 (TTY: 1-800-428-4833)

VSP® EYES OF HOPE® MOBILE CLINICS PROGRAM
PATIENT FREQUENTLY ASKED QUESTIONS

What type of eye exam will I receive?
In most cases, VSP network doctors provide comprehensive eye exams to patients. The exam includes a complete evaluation of the health of your eyes and your vision, including depth perception, peripheral vision and the pupil's reaction to light.

What safety measures are taken at mobile clinic eye exam events?
You can view our safety protocols online at **mobileclinics.vspeyesofhope.com**.

Will I receive a new pair of glasses, if needed, after my eye exam?
After your eye exam, if you need glasses and you have a lower strength single vision prescription, you will likely receive a new pair of glasses the same day as your exam. If unforeseen circumstances arise or you have a higher prescription that requires a bifocal lens, your glasses will be made at a VSP lab. You will receive your new pair of glasses within a few weeks after your exam.

Will I receive a copy of my prescription?
Yes. We will provide a copy of your eyeglass prescription to you at checkout.

What if I lose my prescription or would like a copy of my eye exam record?
You may request a copy of your eye exam record and/or eyeglass prescription by sending us a secure email at **mobileclinic@vsp.com**. Please provide your full name, date of birth, mailing address, date and location of eye exam, and your phone number or email address.

What should I do if my new glasses don't fit properly?
Please take your glasses to a local VSP doctor's office, explain where you originally received them, and ask if they can adjust them to fit properly. To find a local VSP doctor, visit **vsp.com**.

Who do I contact if I have questions about the prescription?
Please call us at **800.877.7195**.

Who do I contact if my glasses are broken or are damaged?
If you received broken or damaged glasses, please call us at **866.549.9301** within sixty (60) days and we will assist you with a replacement. If you break or damage your glasses after receipt, we are unable to provide a replacement.

How can I provide feedback about the care or service I receive today?
There are two ways to provide feedback:

- Visit **eyesofhopestory.com** anytime to tell us how the eye exam and/or glasses you receive through VSP Eyes of Hope have improved your life or daily experience.
- A grievance is written or verbal expression of dissatisfaction regarding VSP and/or a doctor, including quality of care concerns, and includes a complaint, dispute and/or request for reconsideration. Please call **800.877.7195** or visit **vsp.com** to submit a grievance.