Dr. Bryan Friedmann

OPTOMETRIST

Dear Valued Patient,

Thank you for booking an appointment with Dr. Bryan Friedmann. We look forward to welcoming you to our office very soon.

We have implemented stringent infection prevention and control protocols, as well as occupational health and safety practices to prevent the spread of COVID-19. Part of this effort includes transitioning to the **delivery of legally mandated paperwork you need to fill in and sign** prior to your scheduled in-office exam. This gives you time to review them in the comfort of your home and reduces the time you spend physically in the office. We have conveniently compiled these documents for you in this package, and include:

1. **COVID-19 Office Safety Plan** – Please review, sign and date
2. **Privacy Policy Consent Form** – Please review, sign and date
3. **Medical Services Plan Authorization Form** – Please review, sign and date

Our commitment is to continue to provide you with the highest level of diagnostic and therapeutic eye care possible.

We thank you in advance for your understanding,
Dr. Bryan and Lesley Friedmann

COVID-19 Safety Plan

Dr. Bryan Friedmann Optometry Clinic's COVID-19 Safety Plan has been developed in compliance with BC's Centre for Disease Control and WorkSafeBC's guidelines. It accounts for safe physical distancing, hand and respiratory hygiene, use of engineered and administrative controls, and use of personal protective equipment where appropriate. Please read through the following safety measures:

1. **Maximum Occupancy –** 5 people (including doctor & staff) are permitted in the office at any given time.
2. **Arrival Time –** Please come 10 minutes prior to your appointment time for check-in & diagnostic
3. **Come Alone –** Unless you are a minor and/or require a companion.
4. **Barriers and Partitions –** Have been installed at front desk.
5. **Masks –** Patients, doctor and pretest staff must wear a mask. One will be provided if needed.
6. **Personal Protection Equipment –** Doctor will wear a mask, gloves and gown when attending a patient.
7. **Hand Sanitization –**
   a. Health Canada approved hand sanitizer is available upon entering the clinic.
   b. Each exam room has a sink and soap available for hand washing.
   c. Doctor and staff will sanitize their hands before and after each patient encounter.
8. **Staff Health –** Doctor and staff will monitor their health daily and if they start to feel ill, they will self-isolate until well again and the clinic will be closed.
9. **Disinfecting Pretest and Exam Rooms –** All surfaces will be disinfected with Health Canada approved disinfectant between patients.
10. **Waiting Room –** Will be disinfected after each patient encounter.
11. **Virtual Consultations –** Will be provided where clinically appropriate at no charge to the patient.
12. **Screening –** In accordance with BC Centre for Disease Control guidelines, all patients are screened prior to their appointment and asked to reschedule their appointment to a later date if the answer is **Yes** to any of these following questions. Do you, or the person you are inquiring about:

- **Yes** **No** Have any new onset of shortness of breath, coughing, and/or fever?
- **Yes** **No** Been in contact with someone that is confirmed to have COVID-19 in the last 14 days?
- **Yes** **No** Been in a setting in the last 14 days that has been identified by public health as a risk for acquiring COVID-19, such as on a flight, in a workplace with a cluster of cases, or at an event?
- **Yes** **No** Travelled off Vancouver Island in the last 14 days?

I, __________________________, have read Dr. Bryan Friedmann's Optometry Clinic COVID-19 Safety Plan and I agree to comply with its protocols and procedures. I understand that, should I develop any changes to my health as detailed in item number twelve (12) above, I will contact your office by phone or email to reschedule my appointment.

Signature: _____________________ Date: _________________

Privacy Policy and Consent Form

For Dr. Bryan Friedmann to understand your situation and help you, his office will need to collect some health-related personal information about you. If needed, this information may be **shared with other medical practitioners as it pertains to your care**. Our clinic's Notice of Privacy Practices (NPP) complies with the Privacy Regulations issued by Health Canada, and it is in accordance with the **Personal Information Protection Act of British Columbia** (PIPA).

Your **Protected Health Information** contains identifiers like your name, personal health number, address, medications used, or other information that reveals who you are. Your optometric records also display your personal health information. We understand that your health information is personal to you and we are committed to protecting it.

Use and Disclosure of Protected Health Information

Dr. Bryan Friedmann and his staff are **legally required to maintain your personal health related information confidential**. Our office has policies, procedures and other safeguards in place that protect your Personal Health Information from improper use and disclosure. These policies are described in further detail below:

1. **Treatment:** If necessary, medical information may be shared with other healthcare providers directly involved in patient care. For example, a referral to a specialist will require the disclosure of Personal Health Information.
2. **Appointment and Patient Recall Reminders:** Personal Health Information may be used to contact patients as a reminder of a scheduled appointment.
3. **Payment:** Personal Health Information may be used and disclosed to extended health insurance companies on the patient's behalf for the purposes of payment for services.
4. **Lawsuits and Other Legal Disputes:** Personal Health Information may be used and disclosed to respond to a court or administrative order, a subpoena, or a discovery request, or to defend any lawsuit arbitration.
5. **Other Uses and Disclosures:** Release of Personal Health Information in situations not covered by this notice will occur only with your written permission unless it can be reasonably inferred from the statements above.
6. **Revoking Permissions:** Permissions to share Personal Health Information may be revoked in writing at any time. We are unable to take back any previous disclosures made when previous permissions were in effect.

I, ______________________ (Patient Name) hereby give permission to Dr. Bryan Friedmann and his staff to collect and disclose my Personal Health Information to other healthcare providers directly involved in my care. I understand that my Personal Health Information will be protected in accordance with the above Privacy Policy and in compliance with the Personal Information Protection and Electronics Documents Act of British Columbia (PIPEDA).

Patient Signature ________________________ Date ________________

BRITISH COLUMBIA | Ministry of Health

AUTHORIZATION FOR PAYMENT FROM MEDICAL SERVICES PLAN TO OPTED-OUT PRACTITIONERS

This form allows Dr. Bryan Friedmann to receive your Medical Services Plan (MSP) reimbursement directly for services that are MSP benefits. ***It is only valid if it is signed and dated (including the year) by both the patient and Dr. Bryan Friedmann.***

PATIENT INFORMATION AND AUTHORIZATION (PLEASE USE CAPITAL LETTERS)

Patient Last Name	Patient First Name	Patient Personal Health Number (PHN)

Patient Authorization

I, the patient named above, authorize MSP to pay the practitioner named below directly for reimbursements for benefits payable to me under the *Medical and Health Care Services Regulation* for care provided to me. I authorize the practitioner to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed.

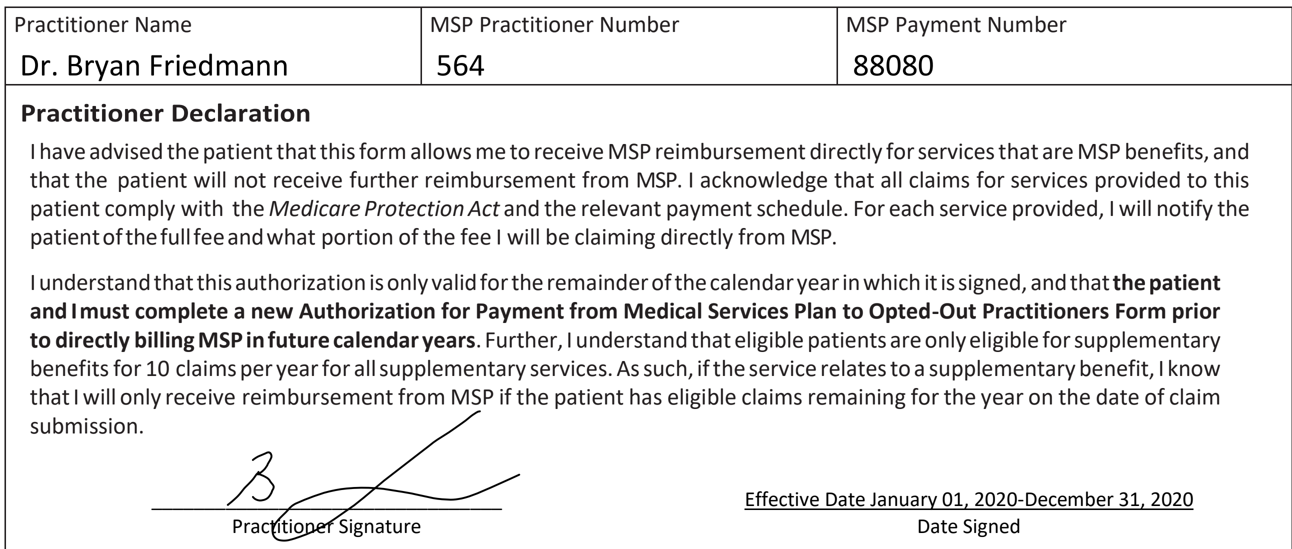
For each service provided, the practitioner will notify me of the full fee and what portion of the fee they will claim directly from MSP.

- For optometry services MSP contributes an amount in accordance with the relevant payment schedule as set out by MSP.

I make this authorization in full knowledge that Dr. Bryan Friedmann will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable).

Patient Signature ____________________ Date Signed ____________________

PRACTITIONER INFORMATION AND DECLARATION (PLEASE USE CAPITAL LETTERS)



Practitioner Name	MSP Practitioner Number	MSP Payment Number
Dr. Bryan Friedmann	564	88080

Practitioner Declaration

I have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that the patient will not receive further reimbursement from MSP. I acknowledge that all claims for services provided to this patient comply with the *Medicare Protection Act* and the relevant payment schedule. For each service provided, I will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP.

I understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and that **the patient and I must complete a new Authorization for Payment from Medical Services Plan to Opted-Out Practitioners Form prior to directly billing MSP in future calendar years**. Further, I understand that eligible patients are only eligible for supplementary benefits for 10 claims per year for all supplementary services. As such, if the service relates to a supplementary benefit, I know that I will only receive reimbursement from MSP if the patient has eligible claims remaining for the year on the date of claim submission.

Practitioner Signature

Effective Date January 01, 2020-December 31, 2020

Date Signed

The information contained in this form is collected for the purposes of recordkeeping, claims administration and payment, and to otherwise administer and enforce the *Medicare Protection Act*. If this personal information is being collected by a private practitioner, the collection is occurring with your consent under the *Personal Information Protection Act*. Please speak with your practitioner or contact Health Insurance BC at the address or telephone numbers below if you have questions regarding the collection of your personal information. Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7 Tel: (Lower Mainland) 604 456-6950, (rest of BC) 1 866 456-6950, Fax: 250 405-3592 Web: www.hibc.gov.bc.ca