COMPREHENSIVE PRIVACY AGREEMENT

Clinical procedure-specific informed-consent forms are NOT included here and will be presented separately when needed. Signing this document indicates that you have read, understood and agreed to every section of this Agreement.

Section A — HIPAA Notice of Privacy Practices

The full text of our HIPAA Notice of Privacy Practices can be found below. It describes in detail how we may use or disclose your Protected Health Information ("PHI") and explains your rights under HIPAA.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Insight Vision Center Optometry to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by Insight Vision Center Optometry describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Insight Vision Center Optometry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Thanh Mai, OD, FSLS, at 3151 Airway Ave. Ste M3, Costa Mesa, CA 92626.

With this consent, Insight Vision Center Optometry may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others. They can include my name in this voicemail. Examples include but are not limited to messages about products like glasses or contact lenses available for pickup, medical records information, and appointment reminders.

With this consent, Insight Vision Center Optometry may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Insight Vision Center Optometry may use a photograph of us for my PHI record in Insight Vision center Optometry's EMR and Practice management system. With this consent, Insight Vision Center Optometry may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Insight Vision Center Optometry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Insight Vision Center Optometry may contact me through unencrypted emails and I understand the risk. I understand that there is inherent risk that a third party may be able to read unencrypted emails sent to me but consent to have Insight Vision Center Optometry still be able to communicate information to me in this manner. I understand that Insight Vision Center Optometry is not responsible for unauthorized access of protected health information while in transmission to the individual based on my request. Further, Insight Vision Center Optometry is not responsible for safeguarding information once delivered to me.

By signing this form, I am consenting to allow Insight Vision Center Optometry to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Insight Vision Center Optometry may decline to provide treatment to me.

Mai and Lam Optometric Corporation Notice of Privacy Practices

This Notice of Privacy Practices ("Notice") describes how we may use or disclose your health information and how you can get access to such information. Please read it carefully. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

Uses and Disclosures of Information Without Your Authorization

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

"Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are:

- financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

Other Disclosures and Uses We May Make Without Your Authorization or Consent

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

- disclosures to governmental authorities about victims of suspected abuse, neglect, or
- domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of
- death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA.

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for healthcare prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

Specific Uses and Disclosures of Information Requiring Your Authorization

The following are some specific uses and disclosures we may not make of your health information without your authorization:

- Marketing activities: We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.
- Sale of health information: We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.
- Psychotherapy notes: Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

Your Rights to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information 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 such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

Your Individual Rights

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- To amend health information. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request.
- We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
- was not created by us, unless the person that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for us,
- is not part of the information you would be permitted to inspect or copy, or
- is accurate and complete.
- To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years

prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- To designate another party to receive your health information. If your request for access to your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Acknowledgement of Receipt
I acknowledge that I received a copy of Mai and Lam Optometric Corporation's, Notice of Privacy Practices.

Contact Person
Our contact person for all questions, requests or for further information related to the privacy of your health information is Dr. Thanh Mai, OD, FSLS, at 3151 Airway Ave., Ste. M3, Costa Mesa, CA 92626.

Complaints
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or Email shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice
We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Section B — Patient Consent for Use & Disclosure of PHI (TPO)
By signing below, you consent to Insight Vision Center Optometry ("the Practice") using and disclosing your PHI to carry out Treatment, Payment and Health-Care Operations ("TPO") as described in the NPP.

You may revoke this consent in writing at any time, except to the extent that the Practice has already relied on it.

Section C — Additional Mandatory Authorizations
1. Manufacturer & Quality-Control Disclosures: You authorize the Practice to share the minimum PHI necessary with its contact-lens and ophthalmic-device manufacturing partners (and their subcontractors) for fabrication, verification, post-market surveillance, and quality-improvement purposes. These partners are bound by Business Associate Agreements to protect your data.
2. Regulatory Reporting: You authorize the Practice to disclose PHI or device-related data, as required, to regulators such as the U.S. Food & Drug Administration or the California Board of Optometry.

Section D — Financial & Attendance Policies
PAYMENTS: I will promptly pay all amounts that have been determined my responsibility by my insurance carrier. I understand that my vision plan coverage and/or health insurance copays, coinsurance and deductibles are between my insurance company and myself. I also understand that if I do not have any insurance coverage any services rendered are my personal responsibility, and that full payment is due at the time of service. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility. If my insurance company does not pay for services rendered by Mai and Lam Optometric Corporation within 45 days, I will be responsible for those charges and will make immediate payment.

Attendance Policy: In order to provide quality care and accommodate all patients, we require a minimum of 24 hours' notice for appointment cancellations or rescheduling. Cancellations made with less than 24 hours' notice, or failure to attend a scheduled appointment without notice ("no-show"), will result in a $100 fee. This fee is not covered by insurance and will be the responsibility of the patient. By scheduling an appointment, you acknowledge and accept this policy. This policy is in place to ensure fairness and to support timely access to care for all patients.

Section E — Governing Law & Jurisdiction
This Agreement, and any dispute arising from the provision of services, shall be governed by the laws of the State of California. You agree that the exclusive venue for any legal action shall lie in the state or federal courts located in Orange County, California, and you hereby submit to the personal jurisdiction of those courts.

Section F — Contact Lens Prescription
Contact Lens Prescription Signed Acknowledgment Form Included below is important information to review prior to receiving your contact lens prescription. The Centers for Disease Control and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free-especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment." The CDC recommends the following for contact lens wearers: Schedule a visit with your eye doctor at least once a year. Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision. Understand that eye infections that go untreated can lead to eye damage or even blindness. The Food and Drug Administration (FDA) indicates: "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional." Symptoms of Eye Infection include: Irritated, red eyes. Worsening pain in or around the eyes-even after contact lens removal. Light sensitivity. Sudden blurry vision. Unusually watery eyes or discharge. By signing below, I acknowledge that I was provided with a copy of my contact lens prescription at the completion of my contact lens fitting.

Section G — Acknowledgement & Signature

I have read (or had read to me) the entire Comprehensive Privacy & Administrative Agreement and understand its contents. I acknowledge receipt of the Notice of Privacy Practices and agree to the mandatory consents above. Optional consents below may be accepted or declined without affecting my care.

Section H — Media & Image Release

You grant the Practice the right to photograph, film, record and edit your image, likeness, and voice, and to publish, distribute, or display such recordings worldwide in any medium, for the promotional and educational purposes listed below. You waive the right to inspect or approve the finished product.

I hereby grant permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video without payment or any other consideration to Mai and Lam Optometric Corporation, doing business as Insight Vision Center Optometry, and its affiliated practices or business collaborators (collectively referred to as "the Practice").

Photographic, audio, or video recordings may be used for the following purposes:

- educational and informational presentations
- website and social media channels
- educational and informational audio and video
- interior office displays and artwork
- promotional materials
- recording by security cameras for safety
- clinical documentation

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. I hereby authorize the Practice to edit, alter, copy, exhibit, publish, or distribute this photo for the purposes identified to promote the Practice or for any other related, lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge the Practice from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. There is no geographic limitation on where these materials may be distributed.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material.

You authorize the Practice to use de-identified clinical data, quotes, testimonials, photographs, audio and video recordings of you for its websites, social-media channels, printed materials, interior displays, presentations and other lawful promotional or educational purposes.

No Compensation. You waive any right to royalties or other remuneration related to such uses.

Right to Revoke. You may revoke this marketing authorization in writing at any time; revocation applies prospectively and does not require removal of existing materials.

Section I — High-Index Lenses for Minor Patients

This clause becomes effective only if the patient is under 18 years of age and a parent or legal guardian requests high-index plastic lenses instead of the standard impact-resistant lenses recommended by the optometrists at Insight Vision Center.

By signing this form, the undersigned parent or legal guardian acknowledges and agrees that:

- For minors, Insight Vision Center recommends lenses made from impact-resistant materials (e.g., polycarbonate) because they provide the greatest protection against breakage and eye injury.
- At the request of the parent/guardian, high-index plastic lenses—manufactured and finished to satisfy the FDA drop-ball impact-resistance standard (21 CFR § 801.410)—may be dispensed in place of the recommended impact-resistant lenses.
- High-index lenses, while thinner and lighter, are generally more susceptible to cracking or shattering than standard impact-resistant lenses and therefore may offer reduced overall eye-injury protection.
- For sports or other high-risk activities, purpose-made protective eyewear should still be worn over—or in place of—high-index lenses.
- Dispensing optometrists remain fully compliant with California Business & Professions Code § 525 because the finished high-index lenses meet the legal definition of "material resistant to shattering."
- This acknowledgment does not waive or override any state or federal safety requirement.
- The parent/guardian voluntarily assumes any additional breakage risk associated with high-index lenses and agrees to hold harmless and indemnify the optometrists at Insight Vision Center, their owners, and staff from claims or expenses arising specifically from this material choice.

Section J — Technology

Insight Vision Center is committed to enhancing the quality of care and patient experience through the use of advanced technology. As part of this effort, we are implementing a Scribing AI during your visit to assist in recording and documenting the details of your visit, including medical history, symptoms, test results, and physician notes.

By signing this consent form, you acknowledge that you understand and agree to the use of this technology during your visit.

Role of the Scribing AI: The Scribing AI will be used to transcribe the verbal communication between you and your doctor during your visit. The information recorded by the Scribing AI will be securely stored and is subject to the same privacy and confidentiality protections as other medical records. You have the option to decline the use of the Scribing AI at any time. If you choose to opt-out, your physician will manually document the exam and treatment notes, and no AI transcription will be used. The use of the Scribing AI will not affect the quality of your care or your treatment plan. The technology is a tool to help improve efficiency and accuracy in documentation, but your care will remain personalized and based on your unique needs.

By signing below, you acknowledge that you have been informed about the use of the Scribing AI during your visit and consent to its use for the purpose of documenting your exam and related health information. You understand that you may withdraw consent at any time without affecting your medical care. You also agree that your data will be protected in accordance with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Section K — FTC Eyewear and Contact Lenses Modality Consent and Confirmation

Patient Consent Form for Accessing Prescription via Patient Portal

Description of Patient Portal. The patient portal is a secure online platform that allows you to access your prescription information, communicate with your healthcare providers, and manage your health information. This service is designed to enhance your experience and ensure the confidentiality and security of your personal health information.

HIPAA Compliance. The patient portal is fully compliant with the Health Insurance Portability and Accountability Act (HIPAA), which protects the privacy and security of your health information. By using the patient portal, you can be assured that your personal and medical information will be handled in accordance with HIPAA regulations.

Consent. I acknowledge that I have read and understood the information provided above regarding the patient portal. I consent to use the patient portal as a means to access your prescriptions and understand that it is HIPAA compliant.

I hereby consent to the use of the patient portal for accessing my prescriptions.

Section L — Medi-Cal

Insight Vision Center Optometry is not enrolled as a provider with the California Medi-Cal Program. If you are currently a Medi-Cal beneficiary, you are advised that certain services, procedures, or materials provided at this office may be covered by Medi-Cal when rendered by a provider who participates in the Medi-Cal program and obtains prior authorization as required. Because our clinic is not a Medi-Cal provider, we are unable to submit Treatment Authorization Requests (TARs) or bill Medi-Cal on your behalf for any services, exams, or medical devices.

You understand and acknowledge that any services you receive at this office, including but not limited to examinations, diagnostic procedures, medically necessary or elective contact lenses, scleral lenses, or specialty optical materials, will be provided on a private-pay basis only. You agree to accept full financial responsibility for all charges incurred and understand that Insight Vision Center Optometry requires payment in full at the time of service.

You further acknowledge that although some of these services may be considered eligible for reimbursement by Medi-Cal under other circumstances, you are electing to receive care from a non-participating provider and are choosing to proceed with services as a self-pay patient. You understand that by doing so, you may not be entitled to reimbursement from Medi-Cal and that Insight Vision Center Optometry will not submit any claims to Medi-Cal on your behalf.

By signing this agreement, you affirm that you are aware of your Medi-Cal status and that you are knowingly and voluntarily choosing to receive services from a non-Medi-Cal provider. You agree not to seek reimbursement from Medi-Cal for any charges incurred and not to request that Insight Vision Center Optometry refund your payment based on Medi-Cal eligibility. This acknowledgment applies to all services rendered on the date indicated below and remains in effect for future services unless revoked in writing.

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I have read (or had read to me) the entire Comprehensive Privacy & Administrative Agreement and understand its contents. I acknowledge receipt of the Notice of Privacy Practices and agree to the mandatory consents above. Optional consents below may be accepted or declined without affecting my care.

Patient / Legal Guardian Name: _____

Signature (electronic): _____ Date: _____

If signing for a minor or incapacitated adult, please indicate your relationship: _____