PATIENT INFORMATION

Today's Date: _____

Patient Demographics:

Last Name: _____**First Name:** _____ **MI:** _____

Address: _____ City: _____ State: ___ Zip: _____

Phone Numbers: Preferred Phone: ( ) _____ Secondary Phone: ( ) _____

Email Address: _____

Gender: ____ Social Security Number: _____Date of Birth: _____

Single ☐ Married ☐ Divorced ☐ Widowed☐ Name of Spouse:_____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone #: _____ Address: _____

Employer Information:

Employer: _____ Occupation: _____

Insurance Information:

IS THE PATIENT ENROLLED IN ANY MEDICAID PLAN(PRIMARY OR SUPPLEMENT)? NO☐ YES☐

Name of Insured: _____ Relationship to Pt: _____

Social Security # of Insured: _____ D.O.B of Insured: _____

Person responsible for bill (other than patient):_____

I REALIZE THAT I AM RESPONSIBLE TO PAY ANY NON-COVERED SERVICES AND/OR CO-PAYMENTS – PAYABLE AT THE TIME OF SERVICE.

**This includes an eyeglass refraction fee of $50 or a contact lens/eyeglass refraction fee of $75. The refraction is a vision service (glasses/contact lenses) not covered by health insurance companies and will not be billed. However, this may be covered if I have a separate vision policy and I understand I am responsible for that filing. I understand that all out-of-pocket/non covered services are due at the time of service. WE DO NOT BILL ANY HEALTH INSURANCE FOR REFRACTION FEES.

**It is my responsibility to provide this office with current up-to-date insurance information. This office will make every attempt to collect from my insurance company, but if no response, I will be responsible for any uncollected monies due past 60 days of visit. Any accounts turned over for collections, will incur a $25.00 collection fee as well as collection charges and credit reporting. I agree to pay all fees associated with collection of my bill/balance

Patient or HCR Signature: X_____ Date: _____

ALL PATIENTS MUST SIGN/HEALTH INSURANCE CLAIM AUTHORIZATION

** I request that payment of authorized Medicare and/or Medigap benefits, AND ALL COMMERCIAL HEALTH INSURANCE PLANS be made on my behalf to Barrett Eye Care LLC for any services furnished me by providers under this cover. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient or HCR Signature: X_____ Date: _____

BARRETT EYE CARE, LLC.
ERIK S. BARRETT, M.D.
HOWARD BRUMBAUGH, M.D.
COURTNEY GONZALES, O.D.

11450 N. Meridian St. Ste. 120
Carmel, Indiana 46032
Phone: 317-872-8772

11845 N. Allisonville Rd. Ste. 300
Fishers, Indiana 46038
Phone: 317-585-9295

MEDICAL RECORD INFORMATION IS NEVER RELEASED WITHOUT YOUR PERMISSION

I have read the NOTICE OF PRIVACY PRACTICES from Barrett Eye Care, LLC. and wish to authorize one of the following:

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1) INFORMATION WILL ONLY BE RELEASED TO MY HEALTH CARE PRACTIONERS FOR CONTIUINTY OF CARE. ANY OTHER RELEASE WILL REQUIRE A SIGNED RELEASE OF MEDICAL RECORDS WITH ORIGINAL SIGNATURE. I understand this office will continue to safeguard my information as is their practice. I understand this authorization is voluntary and I may revoke this policy, in writing, at any time.

   INITIAL: X _____

2) HAVE YOU APPOINTED A HEALTH CARE REPRESENTATIVE (HCR)? A HCR is someone you have legally appointed to make health care decisions for you. _____ Yes _____ No

   IF yes, fill in name(s) of your HCR(s)

   Name(s) of your HCR(s) _____ Date _____
   _____ Date _____

   I give my consent and authorization for this person or persons I list above to act as my HCR to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also understand that I may revoke this privilege at any time by submitting my request, in writing, to this office.

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL. I give my consent and authorization for the medical or billing staff of my Physician's office to leave Protected Health Care information (PHI) about me or for me on my answering machine or voice mail via the telephone numbers provided to the office. I also understand that I may revoke this privilege at any time by submitting my request, in writing, to this office.

INITIAL: X _____

Signature of patient/representative: X _____**Date:** _____

Signature of witness: _____ Date: _____

**********YOU MAY REFUSE TO SIGN THIS AUTHORIZATION, **********

Note that refusal to sign this authorization will result in the inability of staff/physicians to speak with and/or send visit reports to other physicians. We also may not be able to provide refractions to other facilities without your written release.

Reason for declination of signature: _____

Witness: _____ Date: _____

Patient Health History Form

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Primary Doctor's Name: _____

Please list any medication or supplements you take, prescribed and over the counter:

_____ _____ _____ _____

_____ _____ _____ _____

Are you allergic to any medications? Yes __ No __ Please list: _____

Review of Systems – **Are you currently receiving treatment or experiencing any of the following?**

Either circle condition or write condition

Constitution (fever, sudden weight gain or weight loss, malaise)	☐Yes ☐No	
Eyes (glaucoma, macular disease, cataracts, history of injury or eye surgery, LASIK, PRK, RK)	☐Yes ☐No	
Ear / Nose / Mouth / Throat (hearing loss, sinus issues, sore throat)	☐Yes ☐No	
Cardiovascular (High Blood Pressure, Cholesterol, Heart Conditions, Chest Pain, Heart Attack)	☐Yes ☐No	
Respiratory (Asthma, Emphysema, Coughing, Wheezing, Shortness of Breath)	☐Yes ☐No	
Gastrointestinal (Heartburn, Abdominal Pain, Crohn's Disease, Ulcerative Colitis)	☐Yes ☐No	
Genitourinary (Urinary disease, Bladder issues, Blood in Urine, Reproductive Organ disease)	☐Yes ☐No	
Integumentary (skin conditions, psoriasis, eczema, alopecia)	☐Yes ☐No	
Musculoskeletal (arthritis, unexplained swollen, painful joints)	☐Yes ☐No	
Neurological (migraines, numbness, weakness, headaches)	☐Yes ☐No	
Hematological / Lymphatic (blood disorders, leukemia)	☐Yes ☐No	
Allergic / Immunologic (environmental allergies, seasonal allergies, autoimmune disorder)	☐Yes ☐No	
Endocrine (diabetes type 1, diabetes type 2, Hyperthyroidism, hypothyroidism, kidney disease)	☐Yes ☐No	
Psychiatric (depression, anxiety, bipolar disorder)	☐Yes ☐No	

Family History - Do any of your **blood relatives** have any of the following, if yes, who: Unknown: ☐

Glaucoma: ☐ Yes _____ No ☐

Macular Degeneration ☐ Yes _____ No ☐

High Blood Pressure: ☐ Yes _____ No ☐

Diabetes: ☐ Yes _____ No ☐

Social History?

Do you smoke? ☐ Yes, How much? _____ No ☐

Do you drink (beer/wine/spirits)? ☐ Yes, How much? _____ No ☐

Other pertinent health history:

_____

Physician's Signature _____ Date: _____

Barrett Eye Care
Refraction Policy
As of January 1, 2019

What is a Refraction?

Refraction is the process of determining the amount of nearsightedness, farsightedness and astigmatism that is required, to obtain your best-corrected vision. This process is needed to create a glasses and/or contact lens prescription. **Why is it necessary?** Refractions are sometimes necessary, depending on the patient's diagnosis and/or complaints, at the time of their exam. For example, if a patient is experiencing blurred vision or decreased visual acuity, a Refraction is needed to help determine if the decreased vision is associated with a medical condition or the need for an updated glasses/contact lens prescription.

How much is the Refraction?

A Refraction for an Eyeglass prescription includes the below and costs: $50

- **Testing for your optimal eyeglass prescription**
- **A written Eyeglass Prescription that may be used at our Optical Shop or any retailer of your choosing**
- **Any in-office prescription adjustments within 90 days of that writing**

A Refraction for Contact Lenses and Eyeglass prescription includes and costs: $75

- **Testing for your optimal contact lens and eyeglass prescription(s)**
- **Any necessary trial contact lenses within 90 days of Refraction**
- **Any prescription adjustments within 90 days of your Refraction**
- **In-office contact lens follow up, if necessary, within 90 days of writing**
- **A written contact lens and eyeglass prescription, valid for 12 months, that may be used at our Optical shop or any retailer, of your choosing**

What if I do not want the Refraction?

At the beginning of your exam, let your technician know that you decline to have a Refraction. **If you opt out of having this test, you will NOT be given an updated glasses or contact lens prescription**.

By signing you are acknowledging the receipt of this information.

Patient Name (Print) _____

Patient Signature: _____ DATE_____

BARRETT EYE CARE
Eye Care for All

Fishers: 11845 Allisonville Rd Ste #300
Ph: 317-585-9295
Carmel: 11450 N. Meridian St. Ste #120
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FOR CONTACT LENS WEARERS ONLY NEW or INTENDING

Contact Lens Examination and Fitting

Comprehensive Eye Exam

Before being fit into contact lenses, a comprehensive eye exam is performed to determine your glasses prescription as well as your overall eye health to assure you are a candidate for contact lens wear. If you are a previous contact lens wearer, your doctor will examine for any contact lens related problems and assess the fit and prescription of your current contact lenses. We will also measure the topography, or curvature, of the front part of your eye to determine the best fitting contact lens for your eye.

Your yearly contact lens evaluation and/or fitting is a separate charge from your routine exam

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

Contact lenses are a medical device and your eye doctor has the right to refuse fitting services if proper contact lens care and use guidelines are not being adhered to.

Signing below acknowledges that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting and you understand the terms of this form.

Patient Signature:_____**Date:**_____

PLEASE READ BEFORE SIGNING

THIS MAY AFFECT YOUR OUT OF POCKET EXPENSE.

Barrett Eye Care, LLC.

Erik S. Barrett, M.D.
Howard Brumbaugh, M.D.
Courtney Gonzales, O.D.

At all visits you will be examined by a medical ophthalmology/optometry provider. Your visits are billed to your **HEALTH INSURANCE CARRIER** like any other visit to a medical specialist. **We do not bill for preventative/routine visits**. Preventative/routine coverage is used for screenings and our services are more comprehensive than those covered by any preventative benefit (essentially preventative benefits only cover a basic eye chart test). Our services look at the health of the eye, diagnosing and treating diseases of the eye along with prescribing eyeglasses and contact lenses.

By signing the below, you understand that your claim/visit will be filed with your health insurance carrier and will be subject to any specialist copays and/or medical deductibles that normally apply to your medical care.

_____
Patient Name

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

Vs. 3.4.2021