

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

Note: Medicare is not the same as Medicaid

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 AT THE TIME OF SERVICE.

**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: _____

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.

I do not give consent for the staff of my physicians office to leave PHI about me in any format.

Patient or HCR Signature: **X** _____ Date: _____

**Acknowledgment by Individual or Personal Representative
of Receipt of Notice of Privacy Practices**

I acknowledge receiving a copy of the Notice of Privacy Practices given to me by Barrett Eye Care.

I understand this Notice explains how Barrett Eye Care is permitted to Use and Disclose my Protected Health Information and how Barrett Eye Care must protect the confidentiality of my health information.

I understand I should keep the Notice and refer to it if I have questions. I also understand I should call the Barrett Eye Care Privacy Officer, Cari Novak at (317) 877-8772 or (317) 585-9295 if I have a question or concern about my privacy rights.

Print name of Individual

(If applicable) Print name of Individual's Personal Representative and Relationship to Individual

Signature by Individual or Individual's Personal Representative

Date

OFFICE STAFF USE ONLY IF ACKNOWLEDGMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgment of Receipt:

- NPP given to Individual, who refused to sign.
- NPP was mailed to Individual's home address as stated in records.
- NPP was mailed to an alternate address, at Individual's request.
- NPP was faxed or emailed to Individual, at Individual's request.

Other reason(s) why written acknowledgment not obtained: _____

Signature of Person attempting to obtain signed Acknowledgment

Date

ORIGINAL MAINTAINED IN FILE

BARRETT EYE CARE FISHERS, LLC

**APPOINTMENT OF PERSONAL REPRESENTATIVE
TO RECEIVE PROTECTED HEALTH INFORMATION**

You may rely upon your spouse, relatives or friends from time to time to understand your treatment options, visit your physicians, acquire prescriptions, get test results, and otherwise be involved in your medical care. However, federal law does not allow us to disclose any of this information to these people unless you appoint them as your “personal representatives”.

To appoint an individual as your personal representative, complete this form.

I hereby authorize Barrett Eye Care to release the following protected health information to the individual I have designated:

Name	Relationship	Personal Health Information That May Be Disclosed
	<input type="checkbox"/> Spouse	<input type="checkbox"/> All personal health information
	<input type="checkbox"/> Other Relative	
	<input type="checkbox"/> Friend	OR
	<input type="checkbox"/> Other	One or more of these choices: <input type="checkbox"/> Times of appointments <input type="checkbox"/> Prescriptions & ancillary equipment <input type="checkbox"/> Test results <input type="checkbox"/> Copies of medical records <input type="checkbox"/> Other:

If you wish to designate more than one individual, use an additional form.

I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original appointment.

Patient's Printed Name

Date: _____

Patient's Signature

Patient's Address: _____

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:

OFFICE USE ONLY:

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 _____

****PLEASE READ BEFORE SIGNING****

**THIS MAY AFFECT YOUR OUT OF POCKET
EXPENSE.**

Barrett Eye Care, LLC.

**Erik S. Barrett, M.D.
Courtney Gonzales, O.D.
Shawn Sigler, 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 health insurance carriers for preventative/routine visits.** Preventative/routine coverage is used for screenings and many of 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