NEW PATIENT INFORMATION

Barnhorst Eye Associates welcomes you as our new patient. In order to give you the best medical care, it is important that we have your medical history for our records. Please answer the following questions:

(Please print clearly and fill in completely)

Name (First, M.I., Last): ______________________________

Date of Birth: __________ Age: ________ Gender: Male/Female Marital Status: S M W D

Preferred Language: ________ Race: ________ Ethnicity: ________

Address: ______________________________ Zip Code: __________

Phone Numbers (circle preferred): (Cell) ________ (Home) ________ (Other) ________

Email Address: ______________________________

Social Security #: ______________ Driver's License #: ______________

Employer: ______________ Employer's Address: ______________

Person to contact other than yourself: ______________ Contact Person's Phone #: ________

School Name (if college student): ______________________________

Who referred you to us? ______________________________

Primary Care Physician: ______________ Phone #: ______________

Primary Insurance Carrier: ______________ Secondary Insurance Carrier: ______________

Preferred Pharmacy: ______________ Location: __________ Phone: ________

Responsible Party, Parent, Legal Guardian or Spouse Information

Name: ______________ Relationship to Patient: ______________

Address: ______________________________ Date of Birth: ______________

Home Phone #: ______________ Work Phone #: ______________

Social Security #: ______________ Driver's License #: ______________

Employer: ______________ Employer's Address: ______________

Social Security #: ______________ Driver's License #: ______________

Name of friend or relative not living with you: ______________________________

Their address: ______________________________ Their Phone #: ______________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUI MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

Barnhorst Eye Associates has implemented the following policies and procedures so that the confidentiality of your personal and/or medical information remains confidential.

Barnhorst Eye Associates and all employees working in the practice will keep any information related to you (medical and non-medical) in a confidential manner. However, so that we may provide you with appropriate medical care, for general practice operations and/or for the purposes of obtaining payment, we will, at our discretion, provide information pertaining to the treatment you have received from this practice, the charges for this treatment and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms: US Postal Service, fax submissions, internet submission, voice mail and/or personal communications. The following is a list of the most common types of entities that we would typically provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

Physicians and non-physician providers who work outside of this practice
Medical facilities (hospitals, surgery centers, nursing homes)
Laboratories for the purpose of running medical tests
Other health care providers, such as pharmacies, ambulance services, clinical research organizations and school health departments
Insurance companies (or third party administrator) for the purpose of obtaining payments,
reviewing medical necessity and/or general case management
State or federal agencies that require the submission of specific health related information
Pharmaceutical companies to track intraocular lenses used during cataract surgery

We may mail or email the following to you: New patient forms, appointment correspondence, recall cards, surgery information, news letters, brochures, etc. In addition, we may need to contact you by phone to discuss your appointments, test results, treatments, referrals, an account balance and/or return your phone calls to us. We will use any and all phone numbers provided to us by you for these purposes.

Revised date: 9/15/2010

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Barnhorst Eye Associates will use your health related information for the purposes of providing you with medical treatment, obtaining payment for services rendered and/or through the following mechanisms: US Postal Service, fax submissions, internet submissions, voice mail and/or personal communications. The most common entities that will receive this information are: other providers, facilities, insurance companies and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent. The terms of our "Notice of Privacy Practices" may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment, and/or health care operations. Our physicians are not required to agree with the restriction. If the physicians believe it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

I have received a copy of the "Notice of Privacy Practices" from Barnhorst Eye Associates. I consent to the above noted terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operation. I understand that this consent will remain in effect for six years, or until I revoke it in writing.

Patient name (printed): ______________________________ Date: ________________

Patient, parent or legal guardian signature: ______________________________

Relationship to patient of the person signing : ______________________________

Patient refusal:

The patient, parent or legal guardian has refused to sign the consent form.

Name of patient, parent or legal guardian: ______________________________

Employee witness: ______________________________ **Date:** ________________

Effective date: 12/01/2005

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Information/Communication Release Form

I hereby give permission to Barnhorst Eye Associates office staff to notify me by telephone, fax or email of the following (check all that apply):

Yes ___ No ___ Appointment reminder, either by personal message or recorded message.

Yes ___ No ___ A message to call the office for test results (At no time will test results be left by message).

The individuals named below are authorized to receive information regarding my health care and results of my eye exams from the staff of Barnhorst Eye Associates:

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

I understand that this form is intended to guard my privacy and I have the option to edit this information at anytime.

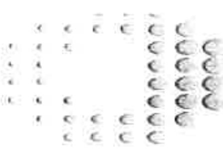
______________________________ ______________

Patient Signature Date

______________________________ ______________

Witness Signature Date

Revised 9/15/2010



PLEASE READ AND SIGN THIS IMPORTANT INFORMATION

FOR COMPLIANCE PURPOSES, A COPY OF YOUR CURRENT PICTURE IDENTIFICATION CARD AND CURRENT HEALTH INSURANCE CARD(S) AS APPROPRIATE IS REQUIRED. WE WILL BE UNABLE TO BILL YOUR INSURANCE UNLESS WE HAVE A CURRENT INSURANCE CARD OR A COMPLETED INSURANCE FORM FOR EACH INSURANCE CARRIER. YOU WILL BE RESPONSIBLE FOR PAYMENT UNLESS WE HAVE ONE OR BOTH OF THE ABOVE TODAY.

PARTICIPATING INSURANCE PLANS: All charges will be billed. All known patient portions and non-covered services will be collected on the day of your visit. Charges determined by your carrier to be your responsibility thereafter will be billed to you.

MEDICARE PATIENTS: Barnhorst Eye Associates is a Medicare participating provider. This means that we will bill Medicare and accept the Medicare allowed fee with the remaining 20% payable by you or your Medicare supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services. All patient portions are payable at the time of service.

MANAGED CARE PLANS: Our practice participates with many Managed Care insurance plans. If you are a member of one of these plans, we will ask you for a referral from your primary care physician. You will be responsible for any copayment deductible and non-covered services, which are payable at the time of service. The balance will be billed directly to your insurance company. Charges determined by your carrier to be your responsibility thereafter will be billed to you.

Contact Lens Evaluation and fitting fee: If you wear contact lenses and require a new prescription there may be fees associated with these services. Payment for contact lens services are not covered by insurance and are expected at the time of service.

NON-PARTICIPATING INSURANCE: If you have insurance with a private carrier for which our providers are considered out of network or do not participate, we will submit your claim for you and **you will be responsible for all charges incurred, payable at the time of your visit. Your private insurance company will reimburse you directly.** Please supply us with a *completed* insurance form at each visit, unless your insurance carrier accepts the standard CMS 1500 form.

NON-COVERED SERVICES AND TAXES: There are some services as well as taxes that your medical insurance may not cover at all and payment for these services are your responsibility. The most common of these in the ophthalmology office is a **REFRACTION**. (The test that gives the doctor important information about your vision and about the health of your eyes and gives us your eye glass prescription.) Payment for this and other noncovered services is collected at the time of your visit. Charges determined by your insurance to be your responsibility thereafter will be billed to you.

APPOINTMENTS: This company charges a $25.00 fee if 24-hour advance notice of cancellation is not provided.

Pt's signature: ______________________________ BEA staff initials: _______

PAYMENTS, DEDUCTIBLES, OTHER: All payments that are your responsibility are due at the time services are rendered. We regret that we are unable to accept payment plans except for emergency cases. Self pay patients paying for services in full today may receive a discount off your visit. Please inquire with one of our patient services representatives before you see the doctor. Cash, VISA, MasterCard, Discover, American Express Personal Check are accepted. There will be a $30.00 service charge from BEA or our designated collection agency for all returned checks. In the event of default, you promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

While the filing of insurance claims is a courtesy that we extend to our patients, some charges such as deductibles and copayments are your responsibility. We will collect these at the time of your visit. If no fees are collected and a bill must be generated a $10.00 billing fee will be assesses to your account.

AUTHORIZATION:

I certify that the information I have provided to Barnhorst Eye Associates, Inc. is true and correct. I acknowledge that I've read the above information. Further, I understand that I am responsible for payment of all charges for services and items provided by Barnhorst Eye Associates. I authorize release of any information from my files including, but not limited to, my medical and financial records necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment / participation with my insurance company.

______________________________ ______________________________

Signature of Patient or Legal Guardian Date

MEDICARE / MEDIGAP LONG-TERM AUTHORIZATION:

I request that payment of authorized Medicare / Medigap benefits be made either to myself or on my behalf to Barnhorst Eye Associates Inc. for any services current or future furnished me by Barnhorst Eye Associates. I authorize Barnhorst Eye Associates Inc., to release to the Center for Medicare & Medicaid Services and its agents, information needed from my files including, but not limited to, my medical and financial records for determination of benefits and/or the benefits payable for related services.

______________________________ ______________________________

Signature of Patient or Legal Guardian Date

REFRACTION SERVICE AND FEE

Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. If you have a medical condition such as Cataracts or Diabetes a refraction maybe necessary to assess the medical condition

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

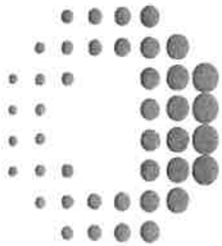
Our office fee for refraction is $45.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

Patient Signature (Parent for Minor) ______________________ Date ______________



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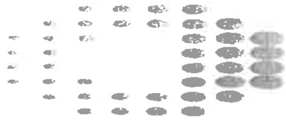
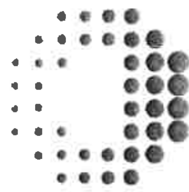


Name:	Date:
Have you noticed a decrease in your vision with your present glasses on. Visual Function Status (circle a responses) complete all lines	
1) Do you have difficulty seeing street signs or to drive? Curbs, freeway exits, traffic lights, halo/glare around lights?	Y N
2) Do you have difficulty seeing TV or movies? Faces, numbers, or printing?	Y N
3) Do you have difficulty reading small print with good light? Books, newspapers, telephone books, medicine labels or instructions?	Y N
4) Do you have difficulty performing detailed work? Sewing, knitting, crocheting, embroidery, baiting a fish hook or other fine tasks.	Y N
5) Do you have difficulty with personal correspondences? Writing checks, reading bills, filling out forms?	Y N
6) Do you have difficulty with leisure activities such as sports or hobbies? Playing cards, bingo, dominoes, or sport activities such as bowling, hunting, golf or tennis.	Y N
7) Do you have visual difficulty functioning around the house? Cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on a watch or using public transportation.	Y N
8) Do you have difficulty recognizing faces of people? In church, grocery stores, clubs and other daily activities?	Y N
9) If you live alone and wish to remain independent, are you able to care for yourself with your present vision?	Y N

Do you have any of the following visual symptoms?

1) Double or distorted vision?	Y N
2) Glare, halos, rings around lights? Daylight or Nighttime	Y N
3) Difficulty with color perception?	Y N
4) Difficulty with depth perception?	Y N
5) Worsening of vision-blurred vision/over decline in vision.	Y N

Signature:______________________________ Date______________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MEDICAL HISTORY QUESTIONNAIRE

Please fill this out to the best of your ability. If unsure of the dates, please estimate. Thank you for your corporation.

Name: ____ Date: ________
Date of Birth: ________ Date of last exam: ________
Height: _____ Weight: _____ Last Known Blood Pressure: _____ Last Known Blood Sugar: ________

HPI: What brings you in today? Have you noticed a change in your vision? ______________________________
____

Do you currently have problems in the following areas? If "YES" please provide information:

Name of Medication	YES	NO	Explanation of Problem
EYES (glaucoma), cataract, retinal, etc)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty			
Itchy			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare / Light sensitivity			
Eye pain or soreness			
Infection of eye or lid (stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
Do you have visual difficulty when driving?			
Do you have problems with night vision?			
Have you ever tried to wear contacts?			
Do you currently wear contact lenses? If "yes", how long have you worn contact lenses?			
Do you currently wear glasses? If "yes", how long have you had the current prescription?			
Have you ever had a blood transfusion?			

(see reverse side)

Ocular Meds: What drops, ointments or oral medication(s) are you currently taking to treat eye condition(s):

Name of Medication	Dose/How Taken

Medical History (List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc):

Diagnoses	Approx. How Long

Systemic Medications: What medication(s) are you currently taking (prescription and over the counter):

Name of Medication	Dose/How Taken

Allergies: Do you have any allergies to any medications (please indicate to what and reaction)?

Allergy	Reaction

Family History:

Disease	YES	NO	Family Member M=Mother F=Father B=Brother S=Sister GP=Grandparent
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			

(see next page)

Social History:

Smoking Status	Never / Former / Current
Marital Status (married, divorced, single, widowed)	
Do you Drink Alcohol	Never / Occasional / 1 or More Per Day
Substance Abuse	
Occupation	
Living Arrangements	
Do you drive?	☐ Yes ☐ No

Review of Systems: Please indicate if you have ever had or now have any problems with the following. Please try to be specific as to the nature of the problem, when it occurs, and what makes it better or worse.

System	How are you feeling?
Allery/Immunology (hayfever, lupus, Sjogrens, etc)	
Cardiovascular (heart, vessels, etc)	
Constitutional	
Endocrine (diabetes, hypothyroid, etc)	
Gastrointestinal (stomach ulcers, intestinal disease, etc)	
Genitourinary (genital, kidney, bladder)	
Hematology/Oncology	
Ears, nose, throat (sinus, ear infection, cough, dry mouth, etc)	
Integumentary	
Musculoskeletal (arthritis, etc)	
Neurological (multiple sclerosis, etc)	
Psychiatric (anxiety, depression, insomnia, etc)	
Respiratory (asthma, emphysema, etc)	

Staff Initials and date:____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____