BARTH VISION & OPTICAL GARY P. BARTH, MD

Dear Patient:

Welcome to Barth Vision & Optical. Dr. Barth has opened his **new** practice in Healdsburg, CA. We are dedicated to serving our patients and will provide you with the most comprehensive and precise care.

If your visit is for an annual eye exam, it is standard of care to dilate your pupils. This will case your eyes to be light sensitive, and some patients may have difficulty with their vision. We will provide dark wraparound eye protection for you when you leave the office. However, you may wish to bring your own sunglasses.

To assist us in serving you, please make sure you bring the following:

- The attached forms completed and signed.
- Medical insurance cards and vision plan coverage information
- Bring a current list of medications and eye drops.
- Bring current glasses and/or contacts being used.
- Referral from your primary care physician if your insurance requires one.
- Insurance co-payment.
- Diagnostic refraction fee of $55.00 when service is provided.

Sincerely,

Appointment Desk Website: www.info@barthvision.org

- 640 Healdsburg Avenue, Healdsburg, CA 95448 **P**: (707) 955-1120 **F**: (707) 955-1135

COVID-19 Information: (effective April, 2020)

Thank you for all you are doing to help slow the spread of COVID-19 in our communities. You are making sacrifices and dealing with significant changes in your daily life. We appreciate your patience as we take precautions to help prevent the spread of COVID-19. These measures are meant to keep you and our staff safe in accordance with CEC recommendations.

- Our staff will wear masks to keep you and each other safe. We ask that you and anyone accompanying you also wear a face covering (mask or scarf).
- We are checking temperatures in accordance with the CDC recommendations at the time of check in.
- Please call to reschedule your appointment if you have a fever, illness, new cough, difficulty breathing, or loss of taste or smell. You should also reschedule if you have been in close contact with someone suspected of COVID-19 infection during the past 2 weeks.
- In our waiting area, please attempt to maintain social distancing when feasible, or if you prefer, you can wait outside in your car. If we are running late, we may take your cell phone number and have you wait outside until we are ready for you.
- Please bring your own reading material.
- To protect our patients and staff, we are following CEC guidelines for proper cleaning of all equipment and surfaces.

Please have only one family member or friend accompany you to the office exam. It is best for them to wait outside or in the car until your consultation and discussion with the doctor occurs. At that point, you can phone them to join us in the examination room or to listen to the conversation via your cell phone.

Thank you for your understanding.

Gary P. Barth, MD

Barth Vision & Optical

Barth Vision & Optical

Name _____
LAST FIRST MI

Address _____

_____

Email _____

DOB _____ **SS #** _____

Sex: **Male** ☐ **Female** ☐ **RACE:** _____

Date _____

Phone Numbers

Home _____

Work _____

Cell _____

INSURANCE

Vision Insurance _____ ID # _____

Address _____

_____ Group # _____

Insured's Name _____

Insured's DOB _____ SS # _____ Relationship to Insured _____

Primary Medical Insurance _____ ID # _____

Address _____

_____ Group # _____

Insured's Name _____

Insured's DOB _____ SS # _____ Relationship to Insured _____

Secondary Medical Insurance _____ ID # _____

Address _____

_____ Group # _____

Insured's Name _____

Insured's DOB _____ SS # _____ Relationship to Insured _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Phone _____

Our *Focus* Is On You

640 Healdsburg Avenue, Healdsburg, CA 95448 • Phone: (707) 955-1120 • Fax: (707) 955-1135 • **barthvision.org**

Barth Vision & Optical

Date: _____

Patient Name: _____

DOB: _____

Primary Physician: _____

What is the reason for your visit today? _____

_____

History of EYE DISEASES or problem? (circle one) YES or NO

	Right Eye	Left Eye
☐ Cataract Surgery	Dates _____	_____
☐ Cornea Surgery	Dates _____	_____
☐ Glaucoma Surgery	Dates _____	_____
☐ Refractive Surgery (LASIK, PRK, RK)	Dates _____	_____
☐ Retinal Surgery	Dates _____	_____
☐ Strabismus (Muscle) Surgery	Dates _____	_____
☐ Vitreous Surgery	Dates _____	_____
☐ Other	Dates _____	_____

History of EYE DISEASES or problem? (circle one) YES or NO
(Examples: Glaucoma, macular degeneration, iritis, or dry eye syndrome)

If yes, explain _____

List current eye drops being used: _____

Do you wear contact lenses? (circle one) YES or NO If yes, are they SOFT or HARD lenses? _____

Family history of eye disease? (circle one) YES or NO If yes, please explain: _____

Major surgeries within the last 10 years: _____

Social History:

Smoking:
- ☐ Current Everyday Smoker
- ☐ Current Some Days Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Type of Tobacco:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Electronic Cigarettes

Alcohol:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Alcohol:
- ☐ Beer
- ☐ Liquor
- ☐ Wine

Recreation Drugs:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily
- ☐ Frequently
- ☐ Heavy

Type of Drug:
- ☐ Amphetamines
- ☐ Cocaine
- ☐ IV Drugs
- ☐ LSD
- ☐ Marijuana

Occupation:
- ☐ Business
- ☐ Manual Labor
- ☐ Office Work
- ☐ Retired
- ☐ Student
- ☐ Teacher
- ☐ Driver/Pilot
- ☐ Engineer

Hobbies:
- ☐ Computers
- ☐ Music
- ☐ Sewing/Crafts
- ☐ Sports
- ☐ Travel
- ☐ Golf
- ☐ Hunting
- ☐ Reading
- ☐ Cards
- ☐ Other _____

Barth Vision & Optical

Date: _____

Patient Name: _____

DOB: _____

PHARMACY: _____

LOCATION: _____

Please list any drug allergies:

☐ No Known Drug Allergies

Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:
Allergy:	Reaction:	Allergy:	Reaction:

List ALL medications you are currently taking including prescription, OTC, as needed, vitamins, topicals, and supplements:

Medication Name	Dosage and Frequency	Reason for Taking

Barth Vision
& Optical

Date: _____

Patient Name: _____

DOB: _____

FINANCIAL/INSURANCE POLICY

We have contracted with many insurance carriers or managed care networks to be providers on their plan. Contractually, both the provider and the patient have obligations under these plans. If you have medical insurance, we will help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do have proof of valid insurance, you will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service.
- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract and are not responsible for knowing the specific benefits of your plan.
- Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurance companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at the time of service.

We must emphasize that filing of claims is a courtesy we will extend to all our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance to help us in the management of your account.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW:
I hereby authorize Barth Vision & Optical to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Barth Vision & Optical will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature _____ Date _____

Barth Vision & Optical

NOTICE REGARDING EYE REFRACTION

REFRACTION POLICY:

Refraction is a diagnostic process involving steps to determine your eyeglass prescription. An EYEGLASS refraction is NOT covered by most medical insurances, including Medicare. Our office has a $55 fee for determining an eyeglass prescription. If the patient chooses to request an eyeglass prescription in addition to the diagnostic refraction, the fee will be collected along with any co-pays at the time of service.

ACKNOWLEDGEMENT:

I have read the above information and understand that if I choose to request an eyeglass prescription that it is a non-covered service, I accept full financial responsibility for the cost of determining the refractive prescription. I understand that my co-pay is a separate cost from the eyeglass prescription.

Patient Name (printed)

Patient or Guardian Signature Date

Barth Vision & Optical

PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to: plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Most specifically to: (1) obtain payment from designated third party payers, (2) conduct normal health care operations such as quality assessments or evaluations, prior authorizations, and physician certifications.

By my signature below, I consent to, and acknowledge that Barth Vision & Optical may use & disclose may Protected Health Information (PHI) to carry out the following:

1. Plan and provide for my care and treatment.

2. Communicate to other healthcare professionals who may contribute or participate in my care and treatment.

3. Obtain authorization, confirm service provided and collection payment from third-party payers and discuss financial account with our billing agency – Practice Management Group.

4. Perform routine healthcare operations such as the review of records from healthcare professionals.

I also consent to Barth Vision & Optical to:

1. To leave a message at my home, cell or office to assist the practice in carrying out routine healthcare operations such as appointment reminders, insurance items and any call pertaining to, or my assessment of, my clinical care.

2. To mail to my home or office any items that assist the practice carrying out routine healthcare operations such as appointment reminders, test results, patient information forms and patient statements.

I understand that I have the right:

1. I have reviewed and acknowledge that a copy has been offered/provided of Notice of Privacy Practices of Barth Vision & Optical.

2. To revoke this consent in writing, except to the extent that Barth Vision & Optical may have already made PHI available to obtain payment from designated third-party payers, or conduct normal health care operations prior to this request.

3. To request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and that Barth Vision & Optical is not required to agree to the restrictions requested.

I acknowledge that I have read and understand all the above information and have answered the questions with correct and up to date information.

Signature:_____ DATE:_____

Name:_____

Barth Vision & Optical

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient _____ **Phone #** _____

Date of Birth _____ **SS #** _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical records of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

☐ Continuing Medical Care ☐ Personal Use ☐ School ☐ Insurance ☐ Legal Purposes ☐ Other

The above information may be released:

TO:

_____

Doctor, Hospital, Attorney, Insurance Company, Self Phone Number

_____

Street Address, City, State, and Zip

FROM: **Barth Vision & Optical**
640 Healdsburg Avenue, Healdsburg, CA 95448
PHONE: (707) 955-1120 • FAX: (707) 955-1135

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire twelve (12) months from the date of my signature unless I revoke the authorization prior to that time.

DATE: _____ **SIGNATURE:** _____

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

NOTICE OF PRIVACY PRACTICES

Barth Vision & Optical

640 Healdsburg Avenue, Healdsburg, CA 95448
Phone: (707) 955-1120 • Fax: (707) 955-1135
barthvision.org

EFFECTIVE DATE: July 27, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify effected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our Privacy Officer.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide, or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick, injured or following your death.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information: to review and improve the quality of care we provide, or the competence and qualifications of our professional staff, to get your health plan to authorize services and referrals, for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates" such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates. California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouse or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce healthcare costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with use in organized health care arrangements (OHCAs) for any of the OHCAs health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about you by having you sign in when arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition, or unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures; although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management, or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals, if we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings or to law enforcement officials, we will comply with the requirements set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless, in our best professional judgement, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information, in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, of if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometime required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, medical witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Corners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Change of Ownership. In the event of this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Right

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to; whether to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible; or we will provide you with an alternative format you find acceptable. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our cost for labor, supplies, postage and if requested and agreed to in advance, the cost of preparing an explanation or summary as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosure. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notifications and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosure to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to this notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. If you would like a more detailed explanation of these right of if you would like to exercise one or more of these right, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website:
info@barthvision.org

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer: Peter Covert, Administrator. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights U.S.
Department of Health and Human Services
90 7th Street, Suite 4-100 San Francisco, CA 94103
Customer Response Center:
(800) 368-1019 • Fax: (202) 619-3818 • TDD: (800) 537-7697
Email: ocrmail@hhs.gov

The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints
You will not be penalized in any way for filing a complaint.