Barth Vision
& OPTICAL

Name ______________________________________ **Date** ____________
LAST FIRST MI

Address ______________________________________

____

Email ______________________________________

DOB ______________ **SS #** ______________

Sex: **Male** ☐ **Female** ☐ **RACE:** ______________

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

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
- ☐ Cigars
- ☐ 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

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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

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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. In the event we do not receive a response from you, your account will be sent to our collection agency.

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 ______________________

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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

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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:____

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