BERRY STEWART
EYE CENTER

2790 SW Wilshire Blvd., Burleson, TX 76028
Phone: 817-484-2020 Fax: 817-484-2015

Dear: _____

Thank you for choosing Berry Stewart Eye Center for your eye care. To prepare for your upcoming appointment, please complete the enclosed forms. Properly completed forms will help the front office staff to expedite the organization of your chart to allow you to be seen by the doctor in a timely manner. Also, if possible, please obtain a copy of your medical records from your previous eye examinations.

At the time of your visit with:

Dr. Nathan Berry Dr. Adam Stewart Dr. Jessica Hall

_____ at _____

Please bring the following:

- ✓ The completed forms
- ✓ Your current insurance card(s)
- ✓ Driver's License
- ✓ A listing of any medications you are taking
- ✓ Your eyeglasses
- ✓ Your referral or authorization number if required by your insurance
- ✓ Your medical records from previous eye examinations

During your visit you may have dilation drops placed in your eyes to help the doctor examine you. We will provide you with disposable sunglasses as you check out if you need them. If, however, you are unsure of your ability to drive while dilated, then you may want to bring a driver with you.

We participate with may insurances, and are happy to file your insurance for covered services. For non-covered services or products, payment is expected at the time of service. We also ask that any co-payments be paid at the time of service. Credit cards are gladly accepted. If you have any questions regarding your health insurance coverage, please contact your health insurance company prior to your visit. After your insurance pays, you will be sent a statement for the remaining balance. All patients are asked to pay this balance within 30 days of the receipt of their statement. If you should have any questions, please contact our billing department. Kindly give us 24-hour notice if you need to cancel or reschedule your appointment, so we may offer this time to another patient. Once again, we welcome you and your family as patients. We are dedicated to making your experience here a pleasant one. Please feel free to contact our office with any questions you may have.

Welcome to our office Today's Date: _____

Thank you for choosing Berry Stewart Eye Center. In order to better serve you, we will need the following information:

First Name: M.I. Last Name: Birth Date: M F Marital Status S M W D

Street Address: Home Phone #:

City: State: Zip: Work Phone #:

Email Address: Cell Phone #:

Social Security #: D.L. #: Ethnicity:

Name of Employer: Employer Address: Occupation:

For patients under 18:

Mother Full Name: Father Full Name:

Name of person financially responsible for this account: Phone #:

In case of an Emergency, please contact: Relationship to Patient: Phone #:

Who referred you to our office? Preferred Local Pharmacy, Address, Phone #:

Primary Medical Doctor & Phone #:

Primary Insurance Company Name: Subscriber # or ID#: Group #:

Subscriber Name: Is current insurance through your employer? Yes No

Do you have a Secondary Insurance Company? Subscriber # or I.D. #: Group #:

Name of Spouse: Subscriber Date of Birth: Spouse Social Security #:

Name of Spouse's Employer: Spouse's Work #:

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I also authorize this office to give me reasonable and proper medical care by today's standards. I assign and request payment of medical benefits directly to the physician for services rendered.

Patient, Parent or Guardian signature: Date:

_____

Berry Stewart Eye Center
Medical History Questionnaire

Name: Date of Birth: Date:

_____

1. **Chief Complaint**: Please state the problem we are seeing you for today:

_____
_____
_____
_____

2. **History of Present Illness**: How did this condition happen?

_____
_____
_____
_____

3. **Eye History**: Circle conditions that apply to you:

GLASSES: full time/ distance/ reading
CONTACTS: hard/ soft
CONDITIONS: cataracts; diabetes; macular degeneration; dry eyes; lazy eye; poor color vision; glaucoma; retinal detachment; crossed eyes; poor night vision

Previous Eye Surgery_____
Previous Eye Injury_____
Current Eye Medications_____

4. **Family Eye History**: Circle conditions that apply:

Cataracts; Glaucoma; Macular Degeneration; Diabetes; Retinal Detachment; Lazy Eye; Crossed Eyes; Blindness
Other:_____

5. **Medical History**: Circle any conditions you have presently or have had previously:

High Blood Pressure; Heart Attack; Stroke; Diabetes; Thyroid Disease; Asthma; COPD/Lung Disease; Arthritis; Lupus; Cancer of _____; Migraines; High Cholesterol; Hepatitis; HIV/AIDS;
Other conditions not listed;

_____

Previous surgery other than eye:

_____
_____
_____

6. **Social History**:

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) YES NO
Have you ever had a blood transfusion? YES NO
Do you drink alcohol? YES NO If so, how often? Daily/Weekly/Monthly/Rarely
Do you smoke? YES NO If so, how much? _____
Have you had a recent fall or loss of balance? YES NO
Have you received a:

Pneumonia vaccination? YES NO Date: _____
Flu shot? YES NO Date: _____
Tetanus shot? YES NO Date: _____

Do you have an Advance Directive for Healthcare? YES NO

List any MEDICATIONS you currently take (RX or over-the-counter)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any ALLERGIES to any medications? Yes No
If yes, list the medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any problems in the following areas?

	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, seasonal allergies, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (racing pulse, dizziness, chest pain, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, asthma, bronchitis, emphysema, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (skin cancer, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, epilepsy, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
BLOOD/LYMPH (easy bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
OTHER (cancer, AIDS, HIV+, Hepatitis, etc.)			

Billing Policy for Glasses Prescription (Refraction)

PLEASE READ THE FOLLOWING:
Your signature below states that you understand that if you are refracted you are responsible for the refraction charge. A "refraction" is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. This procedure is not covered by most medical insurance plans including Medicare.

The fee for refraction is $40.00 and is due at the time of service.

Signature: _____ Date: _____

Billing Policy for Contact Lenses

To provide our patients with the highest standard of care, all patients are required to have a comprehensive medical examination prior to contact lens fitting. The contact lens fitting fee is separate from the comprehensive medical exam and is not covered by medical insurance. Contact lens fitting fees vary depending on the type of contact lens with which you are fit.

The contact lens fitting fee includes the contact lens fitting, follow up evaluations for 90 days from the initial contact lens exam, contact lens trials for fitting, and a contact lens care kit.

Contact lens fees

- Initial fit: **soft basic $99, soft astigmatism (toric) $139, RGP $139, soft multifocal $179** applies to first time fit at our clinic or fitting a new type of lens.
- Contact lens maintenance exam: **soft basic $79, soft astigmatism (toric) $119, RGP $119, soft multifocal $159** applies to examination of existing contact lens fit.

Contact lens professional fees do not include the comprehensive medical exam or annual supply of contact lenses.

PATIENT AGREEMENT

- I have been properly instructed in the care and use of my contact lenses. I also understand if I do not follow the instructions for the care of my lenses, I put myself at risk to develop potentially sight threatening complications.
- I will remove the contact lenses and call the office if pain, light sensitivity or blurry vision that does not improve occurs.
- I understand that if I am being treated for a medically related eye concern, my comprehensive eye examination will be billed to my medical insurance. My comprehensive eye examination is not billable toward vision insurance.
- I understand that the contact lens fitting fee is not covered by medical insurance and must be paid at the time contact lens fitting is performed.

Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with

services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (817) 484-2020.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

I acknowledge that I have received the Notice of Privacy Practices issued by Berry Stewart Eye Center.

Please allows access to my medical records to: _____ Relationship: _____

_____

Patients Signature or Authorized Party Date

_____