Welcome to Barnes Professional Eye Care!

Please fill out all information. If you need any assistance, ask the front desk staff.

Demographics:

Last Name: ____________ First Name: ____________ M. I.: ________

Sex: M ______ F ______ Date of Birth: __________ ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed

Address: ____________ City: ____________ State: ________ Zip: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Email: ____________ Occupation: ____________ Employer: ____________

Emergency Contact: ____________ Relationship: ____________ Phone: ____________

Medical Information:

Last Eye Exam: ____________ Eye Doctor/Office: ____________

Last Medical Exam: ____________ Primary Care Provider: ____________

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your current pair of lenses? ____________

Do you wear contacts? ☐ No ☐ Yes If yes, which brand and how old is your current pair? ____________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable ☐ Yes ☐ No

If you drive, do you have visual difficulty when driving? ☐ No ☐ Yes- Please Explain: ____________

Have you ever been diagnosed with:

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Dry Eyes ☐ Keratoconus

☐Retinal Detachment/Disease ☐Eye Infections, chronic ☐ Crossed Eyed ☐ Lazy Eye

Any Other Eye Conditions/Problems? ☐ No ☐ Yes-What Kind? ____________

Have you had any Eye Operations? ☐ No ☐ Yes Type: ____________

Have you had any Eye injuries? ☐ No ☐ Yes Type: ____________

Do you have any Medication or Food Allergies? ☐ No ☐ Yes Type and Reactions: ____________

____

Do you take **any** Medications? ☐ No ☐ Yes - Please list all Prescription/Non-Prescription/Routine use/As Needed Use/Oral Contraceptives/Vitamins/HerbalsSupplements____________

____

Past Medical History/Habits

List major injuries, surgeries, and/or hospitalizations: ____________

You may discuss the following personal information with the doctor if you prefer:

How much tobacco products do you use? ☐ None ☐ Type/Amount/Years: ____________

How much Alcohol do you drink? ☐ None ☐ Type/Amount/Years: ____________

How often do you use illicit drugs? ☐ None ☐ Type/Amount/Years: ____________

Hobbies/Sports:

____

____

Do you currently, or have you had any Chronic/Serious problems in the following areas?

If multiple problems are listed on a line, please circle the problem you are having/have had:

Eyes

Loss of Vision	☐ Yes ☐ No
Loss of Side Vision	☐ Yes ☐ No
Blurred or Distorted Vision	☐ Yes ☐ No
Glares/Halos	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No
Dryness	☐ Yes ☐ No
Excess Tearing/Watering	☐ Yes ☐ No
Mucus/Discharge	☐ Yes ☐ No
Eye Pain or Soreness	☐ Yes ☐ No
Itching	☐ Yes ☐ No
Burning	☐ Yes ☐ No
Sandy/Gritty/Foreign Body Sensation	☐ Yes ☐ No
Redness	☐ Yes ☐ No
Chronic Infection of eye or lid	☐ Yes ☐ No
Stye or Chalazion	☐ Yes ☐ No
Flashes/Floaters in vision	☐ Yes ☐ No
Light Sensitivity	☐ Yes ☐ No
Tired Eyes	☐ Yes ☐ No

Neurological

Headaches/Migraines	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No
Neuromuscular/Movement Disorders	☐ Yes ☐ No

Endocrine

Diabetes	☐ Yes ☐ No
Hypo or Hyperthyroid	☐ Yes ☐ No
Other Gland Disorders	☐ Yes ☐ No

Skin Problems, Type:	☐ Yes ☐ No

Ears, Nose, Mouth,Throat

Allergies/Hay Fever	☐ Yes ☐ No
Chronic Sinus Issues	☐ Yes ☐ No
Chronic Dry Throat/Mouth	☐ Yes ☐ No

Respiratory

Asthma	☐ Yes ☐ No
COPD	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No

Cardiovascular

High Blood Pressure	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No
Cardiovascular Problems	☐ Yes ☐ No

Gastrointestinal

Crohn's	☐ Yes ☐ No
Irritable bowel	☐ Yes ☐ No

Genitourinary

Kidney/Bladder/Prostate Problems	☐ Yes ☐ No
Rheumatoid/Lupus/Scleroderma	☐ Yes ☐ No
Autoimmune Disorders	☐ Yes ☐ No

Lymphatic/Hematological

Anemia	☐ Yes ☐ No
Bleeding Problems	☐ Yes ☐ No

Immunological/Infectious Diseases

Hepatitis ______/HIV/AIDS	☐ Yes ☐ No
Depression/Mental Health	☐ Yes ☐ No

Are you Pregnant or Nursing? ☐ Yes ☐ No

Family History: *Please note parent, grandparents, siblings, children for the following:*

Blindness	☐ Yes ☐ No __________
Cataracts	☐ Yes ☐ No __________
Glaucoma	☐ Yes ☐ No __________
Retinal Detachment Disease	☐ Yes ☐ No __________
Macular Degeneration	☐ Yes ☐ No __________
Diabetes	☐ Yes ☐ No __________
Heart Disease	☐ Yes ☐ No __________
High Blood Pressure	☐ Yes ☐ No __________
Rheumatoid Arthritis, Lupus,	☐ Yes ☐ No __________
Thyroid Disease	☐ Yes ☐ No __________

How did you select our office?

☐ Referred By:____________________________ ☐ Other: ____

Signed: ____ Date: ____________________

Signature of responsible party (parent/guardian if under 18 years old)

Barnes Professional Eye Care
A Professional Corporation

Financial Policy

Fees

Professional fees charged in our office are based upon the time, expertise, and professional guidelines associated with each service. Material charged represent the cost of the material, as well as the time and skill to evaluate the needs of the individual patient.

Insurance

Health insurance is a personal contract between the patient and his/her insurance company. We are providers for multiple insurance companies and will do our best to verify your benefits prior to your exam. It is the patient's responsibility to pay for all non-covered charges, copayments, coinsurance, and deductible.

Payments

Payment for all services will be due at the time they are rendered. If we are billing insurance, your portion may be due at time of service. Payment is required at time of order for materials (i.e. glasses and contact lenses) with any outstanding balances due upon dispensing. No refunds will be issues for cancelled orders if work has been started on your prescription.

No Show/Cancellation Fees

Our office has a $50 no show fee that is to be paid to the office if an appointment is missed or if an appointment is canceled within 24 hours. We require 24 hours notice if you are canceling your appointment to give the office time to fill the appointment slot.

I understand that I am responsible for payment of services at the time of service, including portions that are not-covered by my insurance. If we are billing insurance, your signature below authorized us to release information to the insurance company in order to process your claim, and for payment to our office for charges incurred by you and/or your dependents. You are responsible for any charges not paid by your insurance company. If eligibility cannot be verified or if you do not obait proper referral forms as dictated by your insurance, you will be financially responsible for any charges incurred. If you have any questions regarding your coverage, please contact your insurance company.

Patient Name: ______________________________ Date: ____________

Signature of Responsible Party: ______________________________

Barnes Professional Eye Care
Notice of Privacy Practices

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect upon date of signature, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we may charge you $_.10_ for each page and postage if you want the copies mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you have questions or concerns about our privacy practices, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Jacie Neuhauser **Phone:** 503-646-5194 **Fax:** 503-646-9390 **Address:** 11750 SW Barnes Rd., Ste 120, Portland, OR 97225

Please sign here:____ Date:________________