



1911 N. Commerce
Ardmore, OK 73401

(580) 223-0055
Fax (580) 223-0776

M. Rebecca Barnes, O.D.

Elizabeth Cole, O.D.

Dear Patient,

We are thrilled to have you experience the eyecare of Barnes Vision Clinic. Thank you for allowing us this opportunity.

While we realize filling out paperwork is never fun, insurance companies and Medicare require that it must be done yearly.

Attached you will find:

- Patient Information Form
- Information on the Optomap Retinal Exam
- HIPAA Privacy Practice Policies

In essence of time management, we ask that you complete, sign and bring these forms with you when you come in for your eyecare appointment, as well as:

- Glasses
- Sunglasses
- Contact lenses (If you are wearing disposable contact lenses that we did not prescribe, please bring along the containers that show the lens information for each lens.)

We are located at 1911 North Commerce between BancFirst and Hill Country Cars. If you are heading north on North Commerce, make a left U-turn at North Glen Avenue and we are the second building on your right.

We always try to see our patients on time, and appreciate your promptness. Please allow approximately 1-1½ hours for your visit in our office. We want to make sure all your questions are answered and you are not rushed.

If circumstances arise that you need to change your appointment time, please give us as much notice as possible to allow someone else an eyecare opportunity.

Fees, including co-payments, are due at the time of your visit. We do accept cash, checks, Visa, and Mastercard only. We also offer CareCredit which is a health care expense only credit card. For more information go online to www.carecredit.com.

Please bring both your vision plan information as well as your **major medical insurance information.** We are recognized as physicians specializing in the eyes, so we may be able to submit your visit (if there is a medical reason) to your medical insurance for you.

We hope the provided information is of assistance. If there are any questions please call. We are looking forward to providing you with a "WOW" experience in eyecare!

Best regards,

Dr. Rebecca Barnes, Dr. Elizabeth Cole and Team



optomap[®] Retinal Exam

“TO SEE IS TO KNOW, TO NOT SEE IS TO GUESS”

WE DON'T WANT TO GUESS ABOUT THE HEALTH OF YOUR EYES

For the first time, we can now view the entire interior of your eye without dilation. The Optomap takes a 200 degree panoramic digital image of the interior part of the eye that allows Dr. Barnes and Dr. Cole to view **ten times** the information previously available. Potentially sight-threatening conditions can be detected earlier.

SEVEN IMPORTANT POINTS:

- Our doctors strongly recommend the screening for all of their patients.
- The Optomap is an exceptional diagnosis tool for children.
- The scan is totally safe.
- There is no blurring of vision.
- There is no pain.
- The image obtained remains part of your permanent record.
- You can view the image along with the doctor.

The fee for the Optomap Screening is \$32.00. If eye diseases are observed, additional interpretation and testing may be required, which can be submitted to your medical insurance carrier. **Dr. Barnes and Dr. Cole strongly recommend this technology for adults & children as a means of significantly enhancing their ability to detect serious eye conditions such as Diabetic Retinopathy, Hypertensive Retinopathy, Retinal Holes, Tears and Detachments, Macular Degeneration, Malignant Melanomas, and Glaucoma, as well as many other peripheral retinal diseases.** However, you have the option to decline this procedure. If you decide not to have this procedure done a dilation of your eyes may be recommended to view the retina to our satisfaction. If you have any questions or concerns, please don't hesitate to ask any of our staff or doctors.

Barnes Vision Clinic

General Information

Date: _____

Last Name: _____ First Name: _____ MI: _____ Preferred Name: _____

DOB: _____ Age: _____ SSN: _____

Please check all that apply: Male Female Minor Single Married Other Full Time Student

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer/School: _____ Occupation/School Grade: _____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone # _____

Spouse or Parent's Names: _____ Person Responsible For Account: _____

Whom may we thank for referring you to us: _____ Newspaper Yellow Pages Dr. Referral

CASE HISTORY / REASON FOR VISIT: Please fill in all blanks if not applicable mark N/A.

Date of Last Medical Exam: _____ Primary Physician/Clinic: _____

Date of Last Eye Exam: _____ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes / No / All the time / Sometimes / Work Only / Reading only / Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes / No

Do you wear contacts? Yes / No Type: _____ Are you interested in wearing contact lenses? Yes / No

Wearing schedule: **Daily** **Overnight** Replacement schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had eye injuries? Yes / No Which Eye? _____

Have you ever had eye surgery? Yes / No Why? _____

Have you used eye medication? Yes / No Why? _____

Are you currently pregnant or nursing? Yes / No / N/A

OPTOMAP Please check one that applies: (Our physicians recommend this test be performed annually.)

____ choose to have the Optomap ____ against medical recommendation, decline the Optomap ____ need more information

Have you ever been diagnosed with?

Cataracts: Yes / No When were you diagnosed? _____

Glaucoma: Yes / No When were you diagnosed? _____

Macular Degeneration: Yes / No When were you diagnosed? _____

What are your visual symptoms [With or without glasses or contact lenses] Please check any that apply:

Please circle Right (R), Left (L) or Both (B), along with severity 1 (Low) 2 (Moderate) 3 (High)

Example: [X] Blurred Vision/Distance (R) L B (1) 2 3

[] Blurred Vision/Distance R L B 1 2 3 [] Dry Eyes R L B 1 2 3 [] Headaches R L B 1 2 3

[] Blurred Vision/Near R L B 1 2 3 [] Red Eyes R L B 1 2 3 [] Migraine Headaches R L B 1 2 3

[] Double Vision R L B 1 2 3 [] Watery Eyes R L B 1 2 3 [] Loss of Vision R L B 1 2 3

[] Eye Strain R L B 1 2 3 [] Wandering Eyes R L B 1 2 3 [] Crossed Eyes R L B 1 2 3

[] Eye Infections R L B 1 2 3 [] Mucus Discharge R L B 1 2 3 [] Light Sensitive R L B 1 2 3

[] Eye Pain/Soreness R L B 1 2 3 [] Floaters or Spots R L B 1 2 3 [] Sandy/Gritty Feeling R L B 1 2 3

[] Tired Eyes R L B 1 2 3 [] See Flashes R L B 1 2 3 [] Poor Color Vision R L B 1 2 3

[] Burning Eyes R L B 1 2 3 [] See Halos R L B 1 2 3 [] Droopy Lid R L B 1 2 3

[] Itchy Eyes R L B 1 2 3 [] Poor Night Vision R L B 1 2 3

Staff Initials _____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): Please check if any of the following **APPLIES** to you, and list any medications for each condition that you check. If you have none of these conditions, **PLEASE CHECK NONE**.

Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other: _____	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other: _____	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: _____
Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other: _____	Ocular: <input type="checkbox"/> None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other: _____	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: _____
Neurological: <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other: _____	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other: _____	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other: _____
Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: _____	Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other: _____	Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other: _____
Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____	Medication Allergies: Environmental Allergies: <input type="checkbox"/> None	Alcohol Use: Y N Amount: _____ Tobacco Use: Y N Amount: _____

Please list physical reactions to above allergies:

Please list all medications and/or drugs that you are taking (Including herbal): If you have a list please take it to the front desk for a copy.

Check here if you do not take any medications. _____

- | | |
|--------------------|---------------------|
| 1. _____ For _____ | 6. _____ For _____ |
| 2. _____ For _____ | 7. _____ For _____ |
| 3. _____ For _____ | 8. _____ For _____ |
| 4. _____ For _____ | 9. _____ For _____ |
| 5. _____ For _____ | 10. _____ For _____ |

FAMILY HISTORY: Has anyone in your family (OTHER THAN YOURSELF) been diagnosed with:

Disease/Condition: *If yes please indicate which family member.*

- | | | | |
|---------------------|----------------|----------------|----------------|
| Retinal Detachment | Yes / No _____ | Blindness | Yes / No _____ |
| High Blood Pressure | Yes / No _____ | Cataracts | Yes / No _____ |
| Diabetes | Yes / No _____ | Glaucoma | Yes / No _____ |
| Cancer | Yes / No _____ | Crossed Eyes | Yes / No _____ |
| Heart Disease | Yes / No _____ | Macular Degen. | Yes / No _____ |
| Thyroid Disease | Yes / No _____ | Lupus | Yes / No _____ |

Reviewed By:		
Tech: _____	Dr: _____	Date: _____

Authorization and Release:

Office Policies

Payment is due at the time services are rendered. You will be held financially responsible for any fees not covered by insurance programs. Professional fees are non-refundable.

Insurance cards must be presented at the time of service.

By signing below, you authorize Barnes Vision Clinic to submit insurance benefits on your behalf and release any medical information that may be necessary to process your claim. Once they are submitted, no adjustments may be made. Patients are responsible for understanding their insurance benefits.

HIPAA Privacy Practice acknowledgement

I have received or was offered a notice of privacy practices.

Signature of patient or parent if minor

Date

Office Use Only

Asked patient for Medical and Vision Insurance Cards: Yes No

Copied patient's: Medical Insurance Card Vision Insurance Card No Insurance

Staff Initials _____

Effective date of notice: April 14, 2003
NOTICE OF PRIVACY PRACTICES

M. Rebecca Harden-Barnes, O.D.
Elizabeth Cole, O.D.
1911 N. Commerce
Ardmore, OK 73401
580/223-0055 580/223-0776 Fax
info@barnesvisionclini.com
Contact: Traci Royse

**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.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatments, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission if the situation is outside of our normal uses of PHI for treatment, payment, and health care operations.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the U.S. Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.
APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new in our office, have copies available in our office, and post it on our Web site.

COMPLAINT

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Thank you,
Traci Royse
Office Manager