BARNES
VISION CLINIC

1911 N. Commerce
Ardmore, OK 73401

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

M. Rebecca Barnes, O.D.
Elizabeth Cole, O.D.
Bonnie McCarthick, 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
- ☐ HIPPAA 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 American National Bank. 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, Mastercard and Discover 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, Dr. Bonnie McCarthick and Team

"TO SEE IS TO KNOW, TO NOT SEE IS TO GUESS"

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

With the help of the Optomap Daytona Plus, we can view the entire interior of your eye without dilation. It takes a 220 degree panoramic digital image of the interior part of the eye that allows Dr. Barnes, Dr. Cole, and Dr. McCarthick to view **ten times** the information previously available. Potentially sight-threatening conditions can be detected earlier. The Optomap Daytona Plus has higher resolution & sees things more clearly than ever, especially in the macula. Think the difference between a HDTV versus a standard TV. The Optomap Daytona Plus has autofluorescence which allows Dr. Barnes, Dr. Cole, and Dr. McCarthick to view an additional layer of the retinal and see any tissue that is sick, dying or already dead.

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 $38.00. If eye diseases are observed, additional interpretation and testing may be required, which can be submitted to your medical insurance carrier. **Dr. Barnes, Dr. Cole and Dr. McCarthick 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

While we realize filling out paperwork is never fun, insurance companies and Medicare require that it must be done yearly.
Please give your most recent insurance card to the front desk, so that we can make a copy for our records.
We are thrilled to have you experience the eyecare of Barnes Vision Clinic.
Thank you for allowing us the opportunity to serve you.

General Information Date: _____

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

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

DOB: _____ SSN: _____ ☐ Male ☐ Female

Parent's or Guardians Names: _____ Adults Occupation: _____

Height:_____ Weight:_____ Preferred Language:_____

Race: ☐White ☐Asian ☐American Indian ☐Black or African American ☐Other

Ethnicity: ☐Hispanic ☐African American ☐White ☐Pacific/Asian Islander ☐American Indian ☐Other

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

E-mail Address: _____

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

Emergency Contact: _____ Relation: _____ Phone #_____

Date of Last Medical Exam: _____ Primary Physician's First & Last Name: _____

Are immunizations up to date?☐Yes ☐No List ALL medications taken regularly:☐None List:_____

Does your baby have any known food or drug allergies? ☐No ☐Yes:_____

List any developmental delays or conditions we should know about:_____

Check all that your baby can do at this time: ☐Roll Over ☐Sit ☐Crawl ☐Stand ☐Walk

Has your baby ever had a high temperature (fever)? ☐No ☐Yes, how high _____

List any accidents, eye, or head injuries, and age they occurred:_____

Please list any childhood illnesses your baby has had:

_____ Illness _____ Age at the time Was the illness? ☐Mild ☐Moderate ☐Severe

_____ Illness _____ Age at the time Was the illness? ☐Mild ☐Moderate ☐Severe

Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Other pregnancy issues: _____ APGAR score at birth: _____

Birth Weight: _____ Parents ages at the time of birth: Mother _____ Father _____

List any complications during delivery: _____ Was oxygen used? ☐No ☐Yes

Do any family members have:

Lazy eye (amblyopia) ☐No ☐Yes Eye turn (strabismus) ☐No ☐Yes Eye tumor ☐No ☐Yes

Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

_____

PERSONAL MEDICAL HISTORY: Please check if any of the following **APPLIES** to you. If you don't have any of these conditions **PLEASE CIRCLE Y OR N**.

Constitutional: Y or N	**Ear/Nose/Throat: Y or N**	**Neurological: Y or N**
___Developmental Disability ___Cancer: Type_____ Diagnosed_____ ___Trauma/Large Volume Blood Loss ___Other: _____	___Hearing Loss ___Upper Respiratory Infection ___Other: _____	___Epilepsy ___Cerebral Palsy ___Multiple Sclerosis ___Tumor ___Other: _____
Psychiatric: Y or N	**Cardiovascular: Y or N**	**Respiratory: Y or N**
___Bipolar Disorder ___Anxiety Disorder ___Attention Deficit ___Depression ___Other: _____	___Hypertension ___Congestive Heart Failure ___Vascular Disease ___Heart Disease ___Stroke ___Other: _____	___Asthma ___Emphysema ___Bronchitis ___Sleep Apnea ___COPD ___Other: _____
Gastrointestinal: Y or N	**Musculoskeletal: Y or N**	**Dermatologic: Y or N**
___Crohn's ___Colitis ___Other: _____	___Fibromyalgia ___Arthritis ___Osteoarthritis ___Ankylosing Spondylitis ___Muscular Dystrophy ___Other: _____	___Rosacea ___Psoriasis ___Eczema ___Other: _____
Endocrine: Y or N	**Hematological: Y or N**	**Immunologic: Y or N**
___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other: _____	___High Cholesterol ___Anemia ___Leukemia ___Other: _____	___Rheumatoid Arthritis ___Lupus ___AIDS or HIV ___Other: _____

Ocular: Y or N		**Medication Allergies: Y or N** Please list: **Environmental Allergies: Y or N** **Alcohol Use: Y or N** Amount: **Tobacco Use: Y or N** Amount:
___Glaucoma ___Retinal Detachment ___Macular Degeneration ___Cataract	___Surgery_____ ___ Injury_____ ___Eye turn	

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***.

Cancer	Yes / No _____	Macular Degeneration	Yes / No _____
Thyroid Disease	Yes / No _____	Crossed Eyes	Yes / No _____
High Blood Pressure	Yes / No _____	Retinal Detachment	Yes / No _____
Diabetes	Yes / No _____	Cataracts	Yes / No _____
Other	Yes / No _____	Glaucoma	Yes / No _____

Barnes Vision Clinic

HIPAA Release of information
AUTHORIZATION FORM

I hereby authorize Barnes Vision Clinic and its employees, to release to my Insurance Company and those parties I have listed below, my medical records (includes all records on file). I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid for 12 months from the date of signature below.

I understand that I have a right to revoke this authorization by providing written notice to Barnes Vision Clinic. However, this authorization may not be revoked if Barnes Vision Clinic, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

HIPAA Privacy Practice acknowledgement:
I have also received or was offered a notice of privacy practices.

Confirming Your Appointment
Barnes Vision Clinic uses an automated service to remind you of your upcoming appointments.
Would you like to be reminded? ☐ Yes ☐ No

Patient Health Portal
Barnes Vision Clinic offers access to our Patient Portal.
Are you interested in this service? ☐ Yes ☐ No

Printed name of Patient: _____

Signature of Patient or Legal Representative: _____

Date:_____

I also authorize Barnes Vision Clinic to release my medical information to the additional individuals / medical providers listed below:

( ) Spouse_____ ( ) Other_____

( ) Children_____ ( ) Other_____

( ) Other_____ ( ) Other_____

Office Policies
Payment is due at the time services are rendered. You will be held financially responsible for any fees not covered by your insurance. Insurance cards must be presented at the time of service. Professional fees are non-refundable.

BARNES VISION CLINIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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 must carry out 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 federal 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 or 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
[specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
was not created by us, unless the person that created the information is no longer available to make the amendment,
is not part of the health information kept by or for us,
is not part of the information you would be permitted to inspect or copy, or
is accurate and complete.

To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Rebecca Barnes
580-223-0055

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: September 11, 2013