Notice of Privacy Practices & Financial Policy

Welcome! We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy. Ultimately, any and all financial liability rests with the patient/guarantor.

Our office participates with most major insurance plans. We provide medical as well as routine optometric care to our patients. We DO NOT participate with ALL vision plans. Benefits for eye exams are based on a patient's diagnosis. A DIAGNOSIS CAN NOT BE MODIFIED TO FIT YOUR PLANS BENEFIT. Therefore, if you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to seeing the doctor.

It is the patient's/parent's/legal guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers & employer.
- In accordance with your insurance contract you must be prepared to pay your copay at each visit. We accept cash, checks, Visa, Discover, and Mastercard.
- The patient/guarantor is responsible for all fees associated with the collection of any outstanding account balance. These fees will be added to your account.
- If for any reason a claim is denied due to incorrect insurance information supplied to our office by the patient/guarantor, the guarantor will be responsible for the account balance.
- Contact lens evaluations ARE NOT part of a routine eye exam; additional charges apply and must be paid the day of the contact lens exam. This charge is dependent on the type of lens required for your visual needs.

Payment is due in full at time of service. Any discount (insurance or promotional) on materials must be presented at the time of order to be valid. Material orders require a deposit of one half at time of order and balance due at the time of dispensing. Materials will not be released unless patient balance is zero. Any payment made by check that does not clear your bank account will result in a $30.00 return check fee, which will be added to your account and must be paid before the next visit.

For all services rendered to a minor/dependent patient, the parent/guardian accompanying the patient is responsible for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth, and social security number. We request that you inform the subscriber that their insurance has been used.

By signing below, I acknowledge that I have read and understand the above Financial Policy. I understand and I agree I am financially responsible for all charges for services rendered. I hereby assign all insurance benefits to which I am entitled Barton Eye Care. I authorize the use of this signature on all insurance claims. I authorize Barton Eye Care to release all information necessary to secure payment of benefits.

Name of Patient__________________________________ Patient DOB____________________ Today's Date_______________________

Signature of Patient/Guarantor__________________________________ Printed Name of Parent/Guarantor______________

BARTON EYE CARE
BECKY BARTON, O.D.
SEE THE DIFFERENCE

Patient Name ____

Medical Conditions			**Eye Conditions**		
Heart Disease	Y	N	Glaucoma	Y	N
High Blood Pressure	Y	N	Cataracts	Y	N
High Cholesterol	Y	N	Macular Degeneration	Y	N
Vascular Disease	Y	N			
Ears, Nose, or Throat issues	Y	N	**Family History**		
Asthma	Y	N	Glaucoma	Y	N
Allergies/Hay Fever	Y	N	Macular Degeneration	Y	N
Emphysema/COPD	Y	N	Diabetes	Y	N
Bleeding Problems	Y	N			
Colitis, IBD, or Reflux	Y	N	**Symptoms**		
Genital, Kidney or Bladder disorders	Y	N	Blurred Vision	Y	N
Skin Problems	Y	N	Sudden Loss of Vision	Y	N
Headaches, Migraines, etc.	Y	N	Double Vision	Y	N
M.S., Seizures, or Bell's Palsy	Y	N	Flashes	Y	N
Depression or Anxiety	Y	N	Floaters	Y	N
Diabetes	Y	N	Burning/Gritty/Dryness	Y	N
Thyroid or Other Gland issues	Y	N	Itching	Y	N
Arthritis, Other Muscle/Joint Pain	Y	N	Tearing/Watering	Y	N
Cancer	Y	N	Redness	Y	N
Anemia	Y	N	Pain/Soreness/Tenderness	Y	N
Currently Pregnant	Y	N	Injury/Surgery	Y	N

Please list any surgical procedures within the last few years (including all eye surgeries):________________________________

____

List current medications (or provide a list): ____

Do you have any allergies to medications? If yes, please list: ____

Last Eye Exam: ___________ Last Physical Exam:___________ Height:_____'______" Weight:________ lbs

Medical Doctor and their location:____

Do you or have you ever used tobacco? NO/PREVIOUS/CURRENT If current, list daily amount consumed:________________

Do you wear glasses? YES/NO Do you wear contacts? YES/NO Any concerns with glare or night vision? YES/NO

How many hours daily do you spend looking at a screen?_______ How many hours weekly do you spend outdoors?_______

Patient Information

Name____ Date of Birth________________________________

Preferred Name: _________________________________ Last Four of SS #_________

Address ____City__________________State_______Zip_________

Gender (for insurance billing purposes this needs to be your legal gender): Male ☐ or Female ☐

Patient Occupation: ______________________________ Employer:____

If patient is a student, please list grade and name of school:____

Insurance(s) ____ Policy Holder____

Contact Information

Cell ______________________________ (Primary) Home_____________________________ (Primary)

Email Address ____ ☐ No email

Emergency Contact Name_____________________________ Relation _______________ Phone ________________________

Preferred Pharmacy Name & Location____

How Did You Hear About Us?

__ Social Media __ Internet __ Friend/Family (Name _____________________________________)

__ Other ____

Notice of Privacy

I have read/received a copy of the Notice of Privacy Practices

Signature of Insured/Guardian____ Date _________

Printed Name of Insured/ Guardian ____

Barton Eye Care

Late/Missed Appointment Policy

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment**.

We also understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

A patient’s second missed appointment will result in a restriction of care. Scheduled appointments will not be made for the patient. Rather, we suggest giving us a call the day you will be able to come in for an exam and we will do our best to accommodate your needs.

By signing below you agree you understand and are familiar with this policy. Thank you.

Printed Name ________________________________ Date ______________

Signature ____