

Welcome To Our Office

Today's Date _____

**Thank you for choosing our office. In order to serve you properly,
we will need the following information.**

First Name:	M.I.	Last Name	Birth date:	Sex: 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. #:			
Name of Employer:		Employer Address:		Occupation:	
For Patients under 18: Mother Full Name:		Father Full Name:			
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? Y N		Subscriber # or ID #:		Group#	
Name of Spouse:		Subscriber Date of Birth:	Spouse Social Security #:		
Name of Spouse's Employer:			Spouse's Work #:		
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 Pharmacy, Address, Phone#			
: Primary Medical Doctor & phone#:					

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 Eye Center

2790 SW Wilshire Blvd., Burleson, TX. 76028
(817)484-2020

Dear

Thank you for choosing Berry Eye Center, P.A. for your eye care. We would like to take this opportunity to welcome you as a patient and introduce you to some of our policies and procedures.

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 and 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 on _____ at

Please bring the following:

- ✓ **The completed forms**
- ✓ **Your current insurance card(s)**
- ✓ **Driver's license**
- ✓ **A list of any medications you are taking**
- ✓ **Your eyeglasses**
- ✓ **Your referral or authorization number if required by your insurance**
- ✓ **Your medical records from your previous eye examinations (if not already sent)**

Please allow at least 2 hours for a complete evaluation of your eyes.

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, you may want to bring a driver with you.

We participate with many 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 receipt of their statement. If you have any questions, please contact our billing department.

Kindly give us 24 hours 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 the office with questions you may have.

BERRY EYE CENTER
MEDICAL HISTORY QUESTIONNAIRE (page 1)

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 condition 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 or AIDS;

Other conditions not listed: _____

Previous Surgery other than eye: _____

BERRY EYE CENTER
MEDICAL HISTORY QUESTIONNAIRE (page 2)

Do you have an Advance Directive for Healthcare? Yes No

List any medication you currently take (Rx and over-the-counter):	Do you have allergies to any medications? Yes No
	If YES, list the medications:

Do you have any problems in the following areas? If YES, circle all that apply and provide additional information.

	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, 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.)			

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** Date of last tetanus shot: _____

Do you drink alcohol? **YES NO** How much _____ Do you smoke? **YES NO** How much _____

Berry Eye Center

Nathan Berry, M.D.

Adam Stewart, M.D.

PLEASE READ THE FOLLOWING:

Billing Policies for Refraction

Your signature below states that you understand that if you are refracted (checked for glasses), 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 insurance plans including Medicare.

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

Signature

Date

Berry Eye Center, P.A.
 2790 S.W. Wilshire Blvd.
 Burleson, Tx 76028

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Beneficiary Name: _____ Medicare #: _____

€ **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Berry Eye Center, P.A. for services furnished me by Doctor Berry. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Berry Eye Center, P.A. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

€ **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Berry Eye Center, P.A., if possible or otherwise to me.

€ **OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to Berry Eye Center, P.A.. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Berry Eye Center, P.A.. I authorize Berry Eye Center, P.A. to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

NON-COVERED SERVICES: I understand that Berry Eye Center, P.A.'s contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with Berry Eye Center, P.A. to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Berry Eye Center, P.A., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Berry Eye Center, P.A. for payment. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I also understand that any insufficient fund returned checks may be prosecuted. Any benefits of any type under any policy of insurance are hereby assigned to Berry Eye Center, P.A.. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Berry Eye Center, P.A.. **However, I understand that I am primarily responsible for the payment of my bill.**

6. HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices issued by Berry Eye Center, P.A. that was effective November 1, 2009. Please allow access to my medical records to: _____ Relationship: _____

Beneficiary Signature or Authorized Party	Date