PATIENT INFORMATION SHEET
(PLEASE PRINT)

Doctor: _____
Location: _____
I.D. #: _____
Pref. Location: _____

PATIENT NAME:	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr	_____ *(Last)* *(First)* *(MI)*	_____ *(Date)*
PREFERRED NAME OR NICKNAME (such as "Johnny", "Mrs. Smith" or "Dr. Jones":			
MAILING ADDRESS:	_____ *(Street)* *(City)* *(State)* *(Zip)*		
HOME PHONE: ( )	AGE:	BIRTHDATE:	MALE ☐ FEMALE ☐
CELL PHONE: ( )	SOCIAL SECURITY #:		
E-MAIL ADDRESS:	Yes ❑ No ❑ **Would you like to receive occasional emails from us regarding important eye or practice-related information?**		
EMPLOYER:	WORK PHONE #: ( )		
EMPLOYER ADDRESS:	OCCUPATION:		
SPOUSE'S NAME: ***(If minor, parent's name)***	SPOUSE'S (***or parent***) SS #:	SPOUSE'S (***or parent***) DOB:	

HOW DID YOU HEAR ABOUT THIS OFFICE: (*Please check all those that apply)*

☐ Family Member. If so, who_____ Relationship to you:_____
☐ Friend. If so, who_____
☐ Doctor referral. If so, who?_____ Location? _____
☐ Newspaper ☐ Yellow Pages ☐ Radio ☐ TV ☐ Screening ☐ Self ☐ Billboard ☐ Internet
☐ Other _____

PRIMARY CARE PHYSICIAN & LOCATION:	REGULAR EYE DOCTOR & LOCATION:	
NEAREST RELATIVE or EMERGENCY CONTACT NOT LIVING WITH YOU:	PHONE #: ( )	RELATIONSHIP:
ADDRESS:		
INSURANCE POLICY HOLDER NAME & DATE OF BIRTH (if not the patient). We must have this information to file your claim:		

☐ **I do not authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results and/or treatment with anyone other than myself or my insurance carrier.**

INSURANCE AUTHORIZATION AND AGREEMENT

I hereby authorize Bennett & Bloom Eye Centers to furnish information to insurance carriers concerning my illness and I hereby assign to the doctor all payments for medical services to myself or my dependents.

I understand I am responsible for deductibles, co-pays, non-covered services, coinsurance and items not covered by my insurance company and all fees associated with collection of these amounts.

Signature: _____ Date: _____ By: _____

Our practice is now collecting new demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Bennett & Bloom is dedicated to being your partner in improving patient care. In order for our practice to meet new government regulations please answer the following three questions.

WHAT IS YOUR RACE/DESCENT (please check box)

American Indian or Alaskan Native		**White / Caucasian**	
Asian		**Multi-racial**	
Black or African American		**Other:**	
Native Hawaiian or Other Pacific Islander		**Decline to specify**	

WHAT IS YOUR PREFERRED LANGUAGE (please check box)

English		**Unknown**	
Spanish		**Decline to specify**	

WHAT IS YOUR ETHNICITY / HERITAGE / CULTURAL GROUP (please check box)

Hispanic or Latino		**Unknown**	
Non Hispanic or Latino		**Decline to specify**	

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Bennett & Bloom Eye Centers (the "Practice") using or disclosing my protected health information for providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. This includes appointment reminders via email, text message and voice calls via the contact information you provide.

I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. This includes appointment reminders via email, text message and voice calls via the contact information you provide. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals. Medical scans and pictures are used to document diseases, follow their progression or regression, and guide treatment decisions. I authorize their use for educational purposes including medical and scientific lectures, publications and teaching collections. All identifying data and protected health information will be removed.

Specific Records Expressly Excluded. I DO NOT authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (Check any or all you do not agree to authorize for release):

___Chemical Dependency/Substance Abuse ___Drugs ___Alcohol ___Sexually Transmitted Diseases

I further acknowledge the Practice has made available to me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Name of Patient Date of birth

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

☐ I authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results/treatment and/or account information with the following individuals:

Name	Relationship to Patient	Phone Number

☐ I do not authorize Bennett & Bloom Eye Centers to discuss my symptoms, test results, treatment and/or account information with anyone other than myself, my insurance company or another health care provider involved in my care.

*CONSENT TO RECEIVE MESSAGES –

If at any time I provide a telephone number or email address at which I may be contacted, I consent to receive communications from this practice.

_____ _____

Signature of Patient or Personal Representative Date

Medical Imagery Release Form

Bennett & Bloom Eye Centers

Medical photographs and other images are used to document diseases as well as for industry educational and research purposes. Photographs, angiograms and other types of images and scans may be used for medical and scientific lectures and publications, but all identifying data will be omitted.

I hereby authorize Bennett & Bloom Eye Centers and/or its representative(s) (the "Practice"), to use and disclose photographic or other types of medical imagery or scan that may reveal my health condition for use in medical or scientific lectures, education, publications, illustration, promotion, art, editorial, advertising, training, or any other public relations initiatives, including, but not limited to the inclusion of such image in the Retina Rocks Retina Image and Reference Library.

A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this Authorization, as provided by law. However, I waive the right to approve the finished copy of any electronic or printed material that is produced using the information I have authorized. The Practice will not receive direct or indirect compensation of any kind from a third party as a result of the use or disclosure of my information for the purposes identified above. This release shall be binding upon me and my heirs, legal representatives, and assigns.

The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal and/or state confidentiality rules in such circumstances.

I understand that I can revoke this Authorization at any time by notifying Practice in writing at the following address:

Practice Administrator
Bennett & Bloom Eye Centers
1935 Bluegrass Avenue, Suite 200
Louisville, KY 40215

A revocation will be effective as of the date it is received by Practice. If I do not revoke this Authorization, it shall expire when the personal image above is no longer used by Practice. Protected health information may already have been used and/or disclosed before the revocation is received.

I release and discharge Practice from all liability, including liability for negligence, that in any way arises out of: (1) any and all rights that I may have or may have had in the images of me that I have authorized to be used and disclosed in this Authorization; and (2) any claim that I may have or may have had relating to such use and disclosure of those images of me, including any claim for payment in connection with any distribution of them in any published medium identified in this form.

This Authorization is voluntary. Your treatment, payment, enrollment or eligibility for benefits is not dependent on this Authorization. I certify that I have read this Authorization and Release carefully and fully understand its terms. If I have questions about the use or disclosure of my photographs, videotapes, or other materials of me, I can contact Practice's Administrator at (502) 895-0040.

_____
Date

_____
Patient's Name (printed)

_____
Patient's Signature

_____
Personal Representative's Signature (if applicable)

_____
Personal Representative's Relationship/Authority (if applicable)

Patient Acknowledgement for Dilation, Treatment and FU

Precautions Following Eye Dilation

I understand that my eye(s) might be dilated as part of my examinations or treatments. This will cause my eye(s) to be sensitive to light and to be blurry for at least several hours. This will make it difficult for me to be outside in bright light, to read, or to drive.

I may ask the receptionist at check-out for a free pair of disposable sunglasses if I feel they are needed.

I will have someone else drive following my office visit, or wait in the office until the above effects of the drops have worn off. Failure to follow this advice could result in injury to myself or others.

_____
Patient Signature

_____
Witness Signature

_____
Date

Recommendations for Treatment and Follow-Up Examinations

I understand that it is my responsibility to follow the advice of my doctor(s) at Bennett & Bloom Eye Centers regarding any treatment recommendations. It is also my responsibility to keep any scheduled appointments or surgeries as recommended by my doctor. Failure to do so may lead to permanent eye damage and vision loss.

Your followup appointments will be noted on the receipts given at Check-Out. Please transfer these appointments to your calendar.

You should receive an automated appointment reminder 1 week and again 48 hours before most appointments. You do not have to call our office to confirm these appointments, they are a courtesy to remind you to check your calendar for the time that is being held for you.

_____
Patient Signature

_____
Witness Signature

_____
Date