BARENBURG EYE ASSOCIATES

Patient Registration

❍ **Park** ❍ **Dundalk** ❍ **Ellicott City** ❍ **Pikesville** ❍ **Garwyn**

Dr. Mark Gordon
Dr. Shoshana Cohen
Dr. Joshua Gordon
Dr. Rita Vekker
Dr. Ross Fischer
Dr. Jonathan Ekedahl
Dr. Robert Loeb
Dr. Karl Malicdem
Dr. Selvin Gnanakkan

Patient Name (Last, First, Middle) (Mr./Mrs./Miss/Dr.)

Home Address			City, State, Zip
Home Phone	Work Phone	Cell Phone	Email Address
Patient's Occupation ☐ Student			Social Security Number
Date of Birth	Age	Sex	Marital Status S M D W
Patient's Employer			Referred By

Insurance Information

Name of Primary Insurance		Secondary Insurance	
Address		Address	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Employer		Policy Holder's Employer	
Policy Holder's Date of Birth	Sex	Policy Holder's Date of Birth	Sex
Insurance Number		Insurance Number	
Policy Holder's SS #		Policy Holder's SS#	

Patient's Authorization

I hereby authorize BARENBURG EYE ASSOCIATES to apply for benefits on my behalf for covered services rendered and request that payment be made directly to BARENBURG EYE ASSOCIATES. I certify that all the information in regards to my insurance is correct and further authorize the release of any necessary information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing. I certify that all the information provided on this form is valid and will accept any and all responsibility caused by incorrect information. I understand that I am financially resposible for the charges not covered by insurance.

Patient or Guardian Signature	Date

BARENBURG EYE ASSOCIATES

Ocular and Medical History Questionnaire

Name: _____ Date: _____ Age: _____

Primary Care: _____ Referred by: _____

PLEASE CIRCLE THE CONDITIONS BELOW THAT APPLY TO YOU, AND WRITE ANY ADDITIONAL INFORMATION ABOUT THE CONDITION IN THE SPACE PROVIDED.

Eye Diseases/Problems:

Cataracts _____
Glaucoma _____
Macular Degeneration _____
Dry Eye _____
Lazy Eye/Amblyopia _____
Eye Surgery/Surgeries _____
Retinal Disease _____
Flashes _____
Corneal Dystrophy _____
Eye Injury _____
Floaters _____
Other _____

Systemic Diseases/Problems:

Diabetes _____
High Blood Pressure _____
High Cholesterol _____
Thyroid Disease _____
Heart Disease _____
Arthritis _____
Asthma _____
Allergies _____
STDs/HIV _____
Other _____

Medications: *(Please list ALL medications you are taking, including eye drops)*

_____
_____
_____
_____
_____
_____

Allergies to Medications: *(Please list)*

_____
_____
_____
_____

Latex Allergy **Yes** ☐ **No** ☐

Family Ocular/Medical History: (*Please circle all that apply to your parents, grandparents and/or siblings*)

Glaucoma Cataracts Macular Degeneration Retinal Disease/Detachment

Diabetes High BP Heart Disease

Review of Systems: (*Please check yes or no to the following conditions*)

Yes	No	
☐	☐	GENERAL:Weight Loss, Fever, Headache
☐	☐	EAR/NOSE/THROAT: Hearing loss, Sinus
☐	☐	HEART: Chest Pain, Irregular Heart Rate
☐	☐	RESPIRATORY: Shortness of Breath, Wheezing Asthma, Cough
☐	☐	DIGESTIVE: Heartburn, Diarrhea
☐	☐	MUSCLES: Arthritis, Muscle Aches
☐	☐	OTHERS: (please list)

Yes	No	
☐	☐	NEUROLOGIC: Paralysis, Numbness
☐	☐	SKIN: Rashes, Eczema
☐	☐	PSYCHIATRIC: Depression, Anxiety Mental Illness
☐	☐	ENDOCRINE: Diabetes, Thyroid
☐	☐	CANCER: Any Type
☐	☐	BLOOD: Anemia, Sickle Cell, Bleeding problem

Social History:

Do you smoke: ☐ Yes ☐ No Do you drink alcohol: ☐ Yes ☐ No Recreational Drugs: ☐ Yes ☐ No

BARENBURG
EYE ASSOCIATES

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PLEASE PRINT CLEARLY

Patient Name:	Patient Home Phone Number:
Patient Address:	Patient Cell Phone Number:
	Patient Email Address:
Location of Clinical Records: (Please check one) ❍ Park ❍ Dundalk ❍ Pikesville ❍ Ellicott City ❍ Garwyn	

I authorize Barenburg Eye Associates, Inc. to release health information identifying me under all circumstances pertaining to my eye care.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to:

Ellen Gordon
100 Park Avenue
Baltimore, Maryland 21201

As applicable, we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization. Information will only be provided sufficient to allow authorization and payment of services by a third party.

As applicable, we may call you or send you a postal card, email or text message reminding you to schedule an appointment, or to notify you that your eyewear is ready.

In all instances, Barenburg Eye Associates will show prudence and release only the minimum protected information necessary to a particular disclosure.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____

---------- Please Sign Below ----------

ACKNOWLEDGMENT OF RECEIPT

I ACKNOWLEDGE THAT I READ A COPY OF BARENBURG EYE ASSOCIATES' NOTICE OF PRIVACY PRACTICES.

PATIENT NAME _____

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Barenburg Eye Associates, Inc.
100 Park Avenue
Baltimore, Maryland 21201
Effective Date February 18, 2003

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 treatment, 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 will ask for specific written permission as required by HIPAA regulations.

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 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" who perform health care operations for us and who commit to respect the privacy of your health information;

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 "Privacy Officer" at the address 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 "Privacy Officer" at the address 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 at 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 "Privacy Officer" at the address 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 "Privacy Officer" at the address 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 "Privacy Officer" at the address 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 "Privacy Officer" at the address 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 "Privacy Officer" at the address 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 notice in our office and have copies available in our office.

COMPLAINTS

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 "Privacy Officer" at the address 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.

----------Please Sign Below----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Barenburg Eye Associates' Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Completed _____ Date _____ (Staff Member's Initials and Date)

FILE FORM IN PATIENT RECORD AND PLACE STICKER ACKNOWLEDGING RECEIPT ON OUTSIDE OF FOLDER. PATIENT MAY TAKE A COPY FOR THEIR RECORDS.

BARENBURG
EYE ASSOCIATES

RELEASE TO ACQUIRE MEDICAL RECORDS

I, _____, hereby authorize (name, address, phone of present physician or other health care provider on lines below)

_____

_____

to release any medical information pertaining to me to: (check one)

❒100 Park Avenue
Baltimore, MD 21201
(410) 727-0285
Fax No. (410) 727-7780

❒2300 Garrison Boulevard
Baltimore, MD 21215
(410) 362-2020
Fax No. (410) 362-1042

❒9051 Baltimore National Pike
Ellicott City, Maryland 21043
(410) 465-4080
Fax No. (410) 461-8650

❒1003 North Point Blvd., Suite 605
Baltimore, MD 21224
(410) 282-5544
Fax No. (443) 530-3504

❒100 Park Avenue, 2nd Floor
Baltimore, MD 21201
(410) 383-3401
Fax No. (410)727-7303

❒1829 Reisterstown Road, Suite 210
Pikesville, MD 21208
(410) 653-0200
Fax No. (410) 653-3667

Dated _____ Patient Signature _____

Social Security # _____ Date Of Birth_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____, Source of Authority: _____