BURGETT ♦ KRESOVSKY
EYE CARE

Dear Patient,

Thank you for choosing our practice for your eye care. We look forward to seeing you.

Please bring the completed patient information we have provided, your insurance card, and a photo ID. If you have a medication list, please provide that list and we will make a copy for our records. Our practice offers medical and surgical services. Please be aware that we do not provide prescriptions for glasses or contact lenses.

We have an automated appointment reminder system. You will receive a text the day before your appointment with the date and time of your appointment. If you would rather be called on your cell phone or called on a home phone, please let us know and we will change your appointment reminder method.

We are located off Creasy Lane in the Unity Medical Pavilion. There is handicap parking along the building with additional handicap parking behind the building. General parking is behind the Medical Pavilion building. You may enter through the main entrance doors, or through the patient entrance at the back of the building. An elevator will take you to the second floor, where our office is located, Suite 245.

If you have any questions about our practice or your appointment, please feel free to give us a call.

Sincerely,

Office Staff, Burgett Kresovsky Eye Care

PATIENT'S INFORMATION

Date: _____

Social Security #: _____ Patient Name: _____
Last Name *Legal First Name* *MI* *Suffix*

Permanent Mailing Address: _____

Physical Address: _____
If different from mailing

Home Phone: _____ Employer Phone: _____ Cell Phone: _____

Sex at Birth: ☐ M ☐ F DOB: _____

Employer Name: _____

Employer Address: _____

Patient's E-Mail: _____
No email for children under the age of 18

Primary Care Physician: _____ PCP Phone: _____

PCP Address and/or City: _____ Marital Status: _____

PARENT/GUARDIAN INFORMATION

If the patient is a minor.

Father's Name: _____
Last Name *Legal First Name* *MI* *Suffix*

Father's Mailing Address: _____

Father's Home Phone: _____ Employer Phone: _____ Cell Phone: _____

Father's DOB: _____ Father's SS#: _____

Father's Employer: _____

Employer Address: _____ Father's E-Mail: _____

Mother's Name: _____
Last Name *Legal First Name* *MI*

Mother's Mailing Address: _____

Mother's Home Phone: _____ Employer Phone: _____ Cell Phone: _____

Mother's DOB: _____ Mother's SS#: _____

Mother's Employer: _____

Employer Address: _____ Mother's E-Mail: _____

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: _____

Primary Insurance Co.: _____ Relationship to Subscriber: _____
If the patient is not the subscriber, complete the following.

Subscriber Name: _____
Last Name *Legal First Name* *MI* *Suffix*

Subscriber Mailing Address: _____

Employer Phone: _____ Cell Phone: _____

Sex: ☐ M ☐ F Subscriber DOB: _____ Subscriber SS#: _____

Subscriber Employer: _____

Employer Address: _____

Secondary Insurance Co.: _____ Relationship to Subscriber: _____
If the patient is not the subscriber, complete the following.

Subscriber Name: _____
Last Name *Legal First Name* *MI* *Suffix*

Subscriber Mailing Address: _____

Employer Phone: _____ Cell Phone: _____

Sex: ☐ M ☐ F Subscriber DOB: _____ Subscriber SS#: _____

Subscriber Employer: _____

Employer Address: _____

Would you like to be called by another name other than your legal first name? _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language: _____

Patient's Gender Identity: ☐ Female-to Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Referring Physician _____ Referring Phone: _____

Referring Address and/or City: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Mail Order Pharmacy Name: _____

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EYE CARE

ALLERGIES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EYE MEDICATIONS: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EYE SURGERIES/DISEASES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

OTHER SURGERIES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL ILLNESSES:

1. Diabetes YES ☐ NO ☐
2. Heart Disease YES ☐ NO ☐
3. High Blood Pressure YES ☐ NO ☐
4. _____
5. _____
6. _____
7. _____
8. _____

CURRENT MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. Aspirin YES ☐ NO ☐
9. Coumadin YES ☐ NO ☐
10. Insulin YES ☐ NO ☐

FAMILY HISTORY:

Diabetes YES ☐ NO ☐
Cancer YES ☐ NO ☐
Heart Disease YES ☐ NO ☐
Stroke YES ☐ NO ☐
TB YES ☐ NO ☐
Kidney Disease YES ☐ NO ☐
Blindness YES ☐ NO ☐
Cataracts YES ☐ NO ☐

Glaucoma YES ☐ NO ☐
Macular Degeneration YES ☐ NO ☐
Retinal Disease YES ☐ NO ☐
High Blood Pressure YES ☐ NO ☐
Arthritis YES ☐ NO ☐
Lazy Eye YES ☐ NO ☐
Remarks:

SOCIAL HISTORY:

Smoking Status:
☐ Current Every day Smoker
☐ Occasional Smoker
☐ Former Smoker
☐ Never Smoked

Do you drink alcohol? YES ☐ NO ☐
Drinks Per Day: _____
Do you use Illicit Drugs? YES ☐ NO ☐

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Do you currently have any problems in the following areas?

EYES	Y	N
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Lasik/RK	☐	☐
Retinal Detachment	☐	☐

EAR, NOSE, AND THROAT		
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐

CARDIOVASCULAR		
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐

CONSTITUTIONAL		
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Gain/Loss	☐	☐

RESPIRATORY	Y	N
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

GASTROINTESTINAL		
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hep	☐	☐

GENITO-URINARY		
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
Kidney Stones	☐	☐
History of STD	☐	☐

PSYCHIATRIC		
Anxiety/Depress	☐	☐
Mood Swings	☐	☐
Sleep Problems	☐	☐

ENDOCRINE		
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Excess Urination	☐	☐
Increased Sweat	☐	☐
Fingernail Change	☐	☐

REMARKS:

BLOOD/LYMPHATICS	Y	N
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolong Bleeding	☐	☐
Heavy Aspirin Use	☐	☐

MUSCULOSKELETAL		
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swell	☐	☐

SKIN		
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

NEUROLOGICAL		
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

IMMUNOLOGIC		
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐

Patient Signature: _____ **Date:** _____

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") healthcare professional to provide and perform such medical/surgical care, therapy, tests, procedures, drugs, and other services and supplies as my healthcare professional, in their professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services, and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my healthcare professional to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries or services for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare professional on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted, and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's healthcare professional. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible for making sure insurance payments are processed and paid promptly to my healthcare professional. In addition, I must provide my prompt payment of any amount owed to Unity that is deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating healthcare professional or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services or Unity is a non-participating healthcare professional or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement, and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts, and the terms of this agreement shall remain binding.
h. A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. I am responsible for these fees.
i. Unity Immediate Care (UICC) is not a participating provider with or under the Indiana Medicaid program. As a result, any medical or related services provided by the UICC will not be covered or paid for by the Medicaid program.

OTHER PROVIDERS: I understand that in addition to the attending physician, other healthcare professionals, such as radiologists and pathologists, and other providers, such as laboratories and other medical professionals, may be involved in my care and may separately bill me for their services.

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana, and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or gender identity.

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating healthcare professional to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of the processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

AUTOMATED CONTACT: I understand that Unity and its affiliates and agents will utilize automated messages to contact me using the e-mail and phone numbers I have provided. These messages will provide information to me, such as *appointment information*, *closure messages*, *health services*, *account information, and statements*. These may come as a text message, automated call (whether a cell phone or a landline), or email and will be left at the number or e-mail provided to any Unity healthcare professional. If I receive treatment from multiple Unity healthcare professionals, I may receive multiple messages referencing appointments/services from each office. I understand that I have the right to opt out of any of these contact methods at any time by an opt-out within the text or e-mail message. For voice calls, I can speak to my healthcare provider's office to opt out of voice messages. Different companies are providing the above information to me, and I may need to opt out of each vendor.

PHOTO CONSENT: My healthcare professional may request photos. I consent to have my photographs taken by my healthcare professional or designated associate **if required** and permit the use of photographs for identification, medical records, education, and lectures.

My signature below constitutes my acknowledgment and agreement that I have read and understand the consent, notices, disclosure, and other information provided.

Patient/Parent/Guardian

Print Patient Name: _____ Signature: _____ Date: _____

UNITY HEALTHCARE, LLC
RELEASE OF INFORMATION

Name: _____ Patient Number: _____ DOB _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:	Emergency Contact
1._____	_____	_____	☐
2._____	_____	_____	☐
3._____	_____	_____	☐

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature:_____**Date:** _____