WELCOME TO
BRIGGS OPHTHALMOLOGY & ASSOCIATES, S.C.

LOCATION AND CONTACT INFORMATION:
Our office phone number is (219) 322-2723 Our office address is 24 Joliet Street Suite 201 Dyer Indiana 46311. We are attached to the rear of Franciscan Health Dyer Hospital on the west side of the building. Enter at the Medical Pavilion North and take the elevator or stairs to the second floor.

APPOINTMENT INFORMATION:
Your appointment is scheduled with **Dr. Briggs** **Dr. Kaufman** **Dr. Balagani**

2 DAYS in advance an automated phone system will call to confirm your appointment.

PLEASE ARRIVE FOR YOUR APPOINTMENT on_____ at _____

REGISTRATION:
Enclosed you will find the necessary paperwork that we would like you to fill out **in blue or black ink** and **bring with you to your appointment**. As an option, you may choose to register online **at www.ksbeyedr.com**

Your appointment could take as long as 3 hours; please be prepared for this time. If you are currently taking any eye drops, please bring the bottles with you as well as a current list of all other medications with dosages. Bring any eyeglasses that you are currently wearing with you.

We will have a copy of our Notice of Privacy Practices for you to review upon your arrival at our office. You will be asked to sign and date a form acknowledging that you have reviewed this material. (A copy will be provided to you by request only)

REFRACTION CHARGE:
A refraction is done to determine whether you are nearsighted, farsighted, have astigmatism, and/or whether glasses are necessary or need to be changed. This is an essential part of your eye examination. The refraction most importantly will determine how well you can see. If you're vision cannot be corrected with glasses, you may have some form of eye disease. Medicare and most medical insurance companies will not pay for refractions, although, as you can see above, it is an imperative part of a comprehensive eye examination. You will be required to pay for this service on the day of your exam. Our fee for this service is $40. Be familiar with your insurance coverage as some may provide reimbursement for this service under your vision insurance. (We do not bill to your vision insurance)

DILATION PROCEDURE:
You should plan on having your eyes being dilated the day of your first visit. Dilating drops are used to enlarge the pupils of the eye to allow our doctor to get a better view of the inside of your eye. The dilating eye drops are necessary to diagnose your condition. Dilating drops frequently blur vision for a length of time, which varies from person to person and make you more sensitive to light. Due to this sensitivity, sunglasses should be worn when your eyes are dilated. If you need disposable sunglasses please ask for them when checking out. We recommend you bring a driver for any dilation appointment.

If you have any questions before your appointment, please feel free to call our office.
We look forward to meeting you!

OUR FINANCIAL POLICY

Thank you for choosing Briggs Ophthalmology & Associates, SC as your healthcare provider. Our practice is committed to providing the best treatment and care possible for our patients. If you have insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, any and all financial liability rests with the patient.

We provide MEDICAL and SURGICAL ophthalmologic care to our patients, as opposed to routine eye exams. We do not participate with ANY vision plans.

We require a copy of your current insurance card along with a picture ID at your first visit and we will ask for this information again throughout your years with us. Without a copy of your insurance card, your account will be considered a "self-pay" account. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

SELF PAY PATIENTS: Payment is due, in full at the time of service rendered.

We accept MASTERCARD, VISA, and DISCOVER credit cards, along with MONEY ORDERS and CASH. We do participate with CARE CREDIT.

Our office participates with most major insurance plans. It is the **patient's responsibility** to be sure our Doctor is in their insurance plan. Although we make every effort to obtain accurate information, a verification of benefits is not a guarantee that an insurance carrier will pay a medical claim. The insurance carrier makes the final determination based upon the specific plan negotiated by the insured or insured's employer. Consequently, the patient or guarantor remains ultimately responsible for the charges incurred during each visit.

HMO PLANS:
We do not participate with any HMO plans. You will be considered a self pay patient if you wish to be seen. We have limited participation with HMO/POS plans.

PPO PLANS:
We have agreed to accept the discounted rate from your plan; however, all co-pays must be paid at the time services are rendered.

- **NEW PATIENTS: IF YOUR DEDUCTIBLE HAS NOT BEEN MET a $100.00-$200.00 deposit will be required prior to being seen. Your appointment will be rescheduled until this requirement is met. Also, an additional deposit will be required prior to any eye procedure/surgery. The deposit(s) will be applied to your deductible and any overpayment will be reimbursed.**

MEDICARE:
As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

SECONDARY INSURERS:
We will bill your secondary carrier as a courtesy. Having more than one insurance DOES NOT guarantee that your services are covered 100%. Secondary insurers may pay a portion after your primary carrier pays. You are responsible for any balances after your insurance(s) has cleared.

WORKMAN'S COMPENSATION:
This office will file claims to your employer; you must provide us with the name of your human resources director and/or benefits manager.

MINOR/DEPENDENT PATIENTS:
Any patients under the age of 18 must have a parent or legal guardian accompany them to every visit. The accompanying adult is responsible for payment of the account. The responsibility for payment of the services rendered to minor children whose parents are divorced rests solely with the parent seeking treatment for the child. (Regardless of judgments defined by your divorce decree)

SERVICES NOT COVERED BY YOUR INSURANCE:
Services not covered by your insurance are payable in full prior to or at the time-of-service. We will try to provide prior notification if you are going to receive a service that we know is not or may not be covered by your insurance. Some of these services may include a $40.00 refraction fee, and serum drops.

COLLECTIONS:
We make every attempt to work with our patients before sending accounts to collections. Once an account has been sent to collections, the unpaid balance and a deposit must be paid before patient is seen.

FORMS:
We reserve the right to charge for forms to be completed. Fees vary depending upon the form.

RETURNED CHECK FEE:
There is a $20 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. All future payments must be made with cash, money order or credit card.

CANCELLED APPOINTMENTS
It is the responsibility of the patient to call and cancel scheduled appointments. If you are unable to make your appointment, we ask that you give at least a 24-hour notice. If a 24-hour notice is not given, you will be subject to a cancellation fee of $50. After 3 cancelled appointments without providing at least 24-hour notice, we reserve the right to refuse to accept future appointments from you.

You will be assigned a patient account representative to answer all of your questions.
Feel free at any time to contact our office. 219-322-2723

CHART#_____

DATE:_____ **ENTERED BY:**_____
FOR OFFICE USE ONLY

PATIENT INFORMATION FORM

(PLEASE BE SURE TO SIGN ALL APPROPRIATE AREAS FOUND ON THE BOTTOM OF THIS PAGE)

PATIENT NAME:_____ [ ] MALE [ ] FEMALE SS#_____

ADDRESS:_____ DATE OF BIRTH:_____ AGE:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PLEASE PROVIDE YOUR EMAIL ADDRESS TO RECEIVE A COPY OF YOUR EXAMS:

_____@_____.com

PRIMARY PHONE:_____ SECONDARY PHONE:_____

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED RACE:_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY/STATE/ZIP:_____ WORK #_____

IN CASE OF AN EMERGENCY: NAME:_____ **PHONE #**_____

PRIMARY INSURANCE_____**Are you the SUBSCRIBER? Yes No**

If not who is? Please list their full name, and what is their date of birth?_____

SECONDARY INSURANCE_____**Are you the SUBSCRIBER? Yes No**

If not who is? Please list their full name, and what is their date of birth?_____

PLEASE INDICATE PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

PHONE #:_____ WORK#:_____

Briggs Ophthalmology & Associates, S.C.
MEDICAL/INSURANCE AUTHORIZATION

I request that payment of authorized Medicare/commercial Insurance Co. benefits be made to me or on my behalf to the above named doctor for any services furnished by that physician. I authorize any medical information about me to be released to my Insurance Company and its agents, information needed to determine these benefits payable for services.

x _____
Signature Date

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the doctor named above for any services furnished to me by that physician. I authorize any holder of medical information about me to release my Medigap company any information needed to determine these benefits or the benefits payable for related services.

x _____
Signature Date

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to this Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. Failure to meet any of the above requirements may result in termination from our practice.

x _____ **Date:**_____

Signature of Patient or Responsible Party

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE **chart#_____**

PLEASE FILL OUT THE INFORMATION BELOW AND BRING WITH YOU TO YOUR VISIT.

Your name:_____ male/female Race:_____Ethnicity:_____

Your Birth Date:_____Age:_____

Who referred you to us?_____Office location:_____

DO YOU HAVE ANY EYE COMPLAINTS TODAY?_____

PLEASE LIST **ALL** EYE CONDITIONS THAT YOU HAVE: (Glaucoma, Macular, degeneration, Retina disease, Cataracts, etc...)

_____

PLEASE LIST **ALL** MEDICAL CONDITIONS : (Example: high blood pressure, diabetes, heart disease, stroke ,etc...)

_____

L IST **ALL** SURGERIES: **(including** eye surgeries or lasers.)

_____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS: (circle) YES OR NO

IF YES, PLEASE LIST: _____

Do you smoke? (circle) YES OR NO Have you ever smoked? (circle) YES OR NO Describe_____
Do you drink Alcohol (circle) YES OR NO USE STREET DRUGS (circle) YES OR NO

PRESENT OCCUPATION:_____

PLEASE LIST ALL OTHER DOCTORS THAT YOU SEE AND THEIR PHONE NUMBERS:

_____

_____

FAMILY HISTORY:
Have any of your blood relatives been diagnosed with any eye diseases? Please list:

_____

PLEASE LIST ALL MEDICAL CONDITIONS OF FAMILY MEMBERS AND THEIR RELATIONSHIP TO YOU:

_____

_____

_____

PLEASE SEE REVERSE SIDE OF PAGE →

PLEASE LIST ALL YOUR CURRENT MEDICATIONS:

PLEASE LIST MEDICINES AND STRENGTHS. PLEASE INCLUDE VITAMINS.

EYE DROPS ONLY

NAME OF EYE DROP | WHICH EYE | FREQUENCY

MEDICATION TAKEN BY MOUTH

NAME OF MEDICATION | STRENGTH | FREQUENCY

PHARMACY INFORMATION

LOCAL PHARMACY: _____

STREET _____

CITY _____ STATE _____

MAIL ORDER NAME: _____

STREET _____

CITY _____ STATE _____