WELCOME TO
BRIGGS-BALAGANI OPHTHALMOLOGY & ASSOCIATES

LOCATION AND CONTACT INFORMATION:

Our office address is 1467 Joliet Street Dyer, Indiana 46311.

We are located 1.5 miles east of the Franciscan Alliance Dyer Hospital and 1.5 miles west of Indianapolis Blvd, on the north side of the street.

PLEASE DRIVE TO THE BACK OF THE BUILDING
ENTER IN THE BACK OF THE BUILDING

Our office phone number is (219) 322-2723

APPOINTMENT INFORMATION: Your appointment is scheduled with

Dr. Briggs **Dr. Kaufman** **Dr. Balagani** **Dr. Hawn**

Please arrive for your appointment on______________________________ **at**______________

You will receive an automated phone call or TEXT message 2 DAYS prior to confirm your appointment.

**PLEASE BRING COMPLETED PAPERWORK ALONG WITH YOUR PHOTO ID AND INSUANCE CARD(S)

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**.

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.

REFRACTION CHARGE:

Refraction may be done to determine whether you are nearsighted, farsighted, have astigmatism, and/or whether glasses are necessary or need to be changed. The refraction most importantly will determine how well you can see. Medicare and most medical insurance companies will not pay for a refraction.
Our fee for this service is $45 and must be paid when this service is rendered. Be familiar with your Vision insurance coverage as some may provide reimbursement for this service if provided by someone in your Vision Plan. **WE DO NOT BILL ANY VISION PLANS.**

DILATION PROCEDURE:

YOU SHOULD PLAN ON HAVING YOUR EYES 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!

CHART#________________ APPOINTMENT WITH BRIGGS KAUFMAN BALAGANI HAWN

Entered by:________________

BRIGGS BALAGANI OPHTHALMOLOGY PATIENT INFORMATION FORM

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

First Name:________________ Last Name________________

Gender________________ Date of birth:________________SS#________________

Address:________________City:________________

State:________________Zip Code :________________ **Email address**________________

Home number:________________ Mobile number: ________________

Best contact method: (please circle) **Home** **Mobile** **E-Mail** Back up method: (please circle) **Home** **Mobile** **E-Mail**

Okay to leave a message at these numbers: (please circle) **YES** **NO** Okay to text to these numbers: (please circle) **YES** **NO**

RACE ________________ ETHNICITY ________________ LANGUAGE ________________

MARITAL STATUS: **(please circle)** SINGLE MARRIED WIDOWED OTHER

Emergency Contact Name:________________**RELATIONSHIP:**________________**PHONE #**________________

PRIMARY INSURANCE: ________________POLICY ID# ________________

SECONDARY INSURANCE: ________________POLICY ID#: ________________

PLEASE INDICATE PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME:________________RELATIONSHIP TO PATIENT:________________

ADDRESS:________________CITY/STATE/ZIP:________________BEST CONTACT PHONE #________________

MEDICAL/INSURANCE AUTHORIZATION

________ INITIALS — I request that payment of authorized Medicare/commercial insurance benefits be made on my behalf to the above named facility for any services furnished by physicians. I authorize any medical information about me, to be released to determine these benefits payable for services.

________ INITIALS — I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim. I have read the financial agreement for Briggs Balagani Ophthalmology.

________ INITIALS — I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for upon notification at the next visit or receipt of the first statement, which ever comes first.

________ INITIALS — I acknowledge that I have been offered a copy of Briggs Balagani Ophthalmology & Associate's Notice of Privacy Practices. I understand that I have the right to review the notice prior to signing this consent.

________ INITIALS — I have read and agree with the financial policy terms as listed in this packet.

X

____ **Date:** ________________

Signature of Patient or Responsible Party

NEW PATIENT-NEW PATIENT

SEE OTHER SIDE............

Notice of Privacy Practices
Briggs Ophthalmology & Associates, S.C.

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information

Please review it carefully.

Protected healthy information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic in formation (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental healthy condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices – We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure – This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intent to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone (text)), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI – This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI – This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny you request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information – This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny you request.

You have the right to request a disclosure accountability – This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.