2101 Medical Park Drive, Suite 303
Silver Spring, MD 20902

PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Legal Name:_____**Date of Birth**:_____

Social Security # (Used to Verify Insurance Benefits):_____

Telephone Contact: Mobile Number: (_____) _____ - _____

Home Number: (_____) _____ - _____

Work Number: (_____) _____ - _____

Email Address: _____

Mailing Address: _____

City _____ State _____ Zip _____

WE ARE REQUIRED BY MOST INSURANCE COMPANIES TO ASK THESE QUESTIONS:

Ethnicity (select one):
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ I decline to specify answer

Preferred Language:
- ❑ English
- ❑ _____
- ❑ I decline to specify answer

Race (select one):
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ I decline to specify answer

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CONTINUED

PLEASE PRINT LEGIBLY

Name:_____

Primary Insurance:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Secondary Insurance:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

General Ophthalmologist / Optometrist Name:_____

Phone Number:_____

Primary Care Physician Name:_____

Phone Number:_____

Emergency Contact Name / Relationship:_____

Phone Number(s):_____

Patient Signature:_____Date:_____

Name and Relationship to Patient if other than self:_____

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Lifetime Authorization for Insurance / Medicare / Medicaid

I request that payment of authorized insurance / Medicare / Medicaid benefits be made on my behalf for services furnished me by DC Retina / Neal Adams MD PC.

I authorize any holder of medical or other information about me to release the health care financing administration and/or it's agents information needed to determine these benefits for related services.

I request that payment of authorized insurance / Medicare / Medicaid benefits be made on my behalf to DC Retina / Neal Adams MD PC for any services for me by a physician or supplier. I authorize any holder of medical information about me to release any of my insurance companies any information needed to determine these benefits payable for related services.

I hereby authorize payment directly to DC Retina / Neal Adams MD PC of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denied as a result of preexisting conditions.

I permit a copy of this authorization to be used in place of the original.

Regulations pertaining to Medicare / Medicaid assignment of benefits apply.

I further authorize DC Retina / Neal Adams MD PC to fax the results of my evaluations to my referring physician(s) if appropriate.

Patient Name: _____

Signature: _____

Name of Person (if other than patient): _____

Relationship to Patient (if other than self): _____

Date: _____

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Authorization to Release Information

Without your express written permission, DC Retina / Neal Adams MD PC cannot discuss your treatment or billing information with anyone but you the patient. If you want our office to discuss your treatment and billing information with a **spouse, family member, care giver, etc.**, please list their names below. Please notify us in writing of any changes to the list you complete below:

Name(s):_____

_____

_____

_____

Patient Name: _____

Signature: _____

Name of Person (if other than patient): _____

Relationship to Patient (if other than self): _____

Date: _____

Additional Questions:

Allergies:

Please list any allergies to medicines: _____

Please list any allergies to foods: _____

Please list any environmental allergies: _____

Smoking Status:

Do you smoke currently: ❑yes ❑no

If yes, how much do you smoke? _____

If yes, have you tried to quit smoking? _____

Did you ever smoke in the past? _____

Your Insurance Requires You to Answer the Following Questions:

In regards to your ability to walk, please select one of the following:

- ❑ I am able to walk independently
- ❑ I am able to walk only with assistance
- ❑ I am unable to walk

In regards to your ability to eat, please select one of the following:

- ❑ I am able to eat independently
- ❑ I am able to eat only with assistance

In regards to your ability to dress yourself, please select one of the following:

- ❑ I am able to dress independently
- ❑ I am able to dress only with assistance

In regards to your ability to change and maintain body position, please select one of the following:

- ❑ I am able to change and maintain body position independently
- ❑ I am able to change and maintain body position independently only with assistance

In regards to your ability to carry and handle objects, please select one of the following:

- ❑ I am able to carry and handle small objects
- ❑ I am able to carry and handle small objects only with assistance
- ❑ I am unable to carry or handle small objects

dc retina

Patient Name: _____

Today's Date: _____

Please check yes or no if you have had any of the following symptoms over the last month:

Constitutional Symptoms: ❑yes ❑no recent weight loss ❑yes ❑no night sweats ❑yes ❑no fatigue ❑yes ❑no loss of appetite ❑yes ❑no recent injury	Endocrine: ❑yes ❑no mood swings ❑yes ❑no sweats ❑yes ❑no extra thirsty ❑yes ❑no frequent urination ❑yes ❑no dizziness
Ear, Nose, Throat: ❑yes ❑no runny nose ❑yes ❑no nose bleeds ❑yes ❑no sinus pain ❑yes ❑no ear pain ❑yes ❑no ringing in ears ❑yes ❑no bleeding gums ❑yes ❑no sore throat	Neurologic: ❑yes ❑no headaches ❑yes ❑no seizures ❑yes ❑no numbness of hands or feet ❑yes ❑no weakness of hands or feet ❑yes ❑no poor balance ❑yes ❑no tingling in hands or feet ❑yes ❑no slurred speech
Cardiovascular: ❑yes ❑no chest pain ❑yes ❑no shortness of breath ❑yes ❑no unable to exercise ❑yes ❑no heart palpitations ❑yes ❑no swelling of hands or feet	Respiratory: ❑yes ❑no shortness of breath ❑yes ❑no wheezing ❑yes ❑no coughing ❑yes ❑no coughing with sputum ❑yes ❑no coughing with blood
Gastrointestinal: ❑yes ❑no abdominal pain ❑yes ❑no difficulty swallowing ❑yes ❑no indigestion ❑yes ❑no nausea ❑yes ❑no vomiting ❑yes ❑no diarrhea ❑yes ❑no bloody stools	Genitourinary: ❑yes ❑no incontinence ❑yes ❑no pain on urination ❑yes ❑no blood in urine ❑yes ❑no genital pain ❑yes ❑no genital discharge
Integumentary: ❑yes ❑no itching ❑yes ❑no rash ❑yes ❑no skin discoloration ❑yes ❑no skin wounds ❑yes ❑no skin pain	Musculoskeletal: ❑yes ❑no joint pain ❑yes ❑no joint swelling ❑yes ❑no joint redness ❑yes ❑no stiffness ❑yes ❑no muscular pains
Psychiatric: ❑yes ❑no depression ❑yes ❑no change in sleep pattern ❑yes ❑no mood swings ❑yes ❑no trouble concentrating ❑yes ❑no anxiety	Hematologic: ❑yes ❑no anemia ❑yes ❑no excess bleeding ❑yes ❑no easy bruising
	Allergic: ❑yes ❑no unusual sneezing ❑yes ❑no swollen glands ❑yes ❑no unusual allergic response

My Medication List:

Please include ***all*** prescriptions, over-the-counters, herbals, and nutritional supplements.

Name of Medicine	How Much (What is the Dose)?	How Do I Take It?	When Do I Take It?
	❑mg ❑micrograms ❑IU ❑drop ❑other______	❑by mouth ❑eyedrop ❑inhale ❑injection ❑other ______	❑once a day ❑twice a day ❑three times a day ❑four times a day ❑other ______

Name of Medicine	How Much (What is the Dose)?	How Do I Take It?	When Do I Take It?
	❑mg ❑micrograms ❑IU ❑drop ❑other______	❑by mouth ❑eyedrop ❑inhale ❑injection ❑other ______	❑once a day ❑twice a day ❑three times a day ❑four times a day ❑other ______

Name of Medicine	How Much (What is the Dose)?	How Do I Take It?	When Do I Take It?
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Name of Medicine	How Much (What is the Dose)?	How Do I Take It?	When Do I Take It?
	❑mg ❑micrograms ❑IU ❑drop ❑other______	❑by mouth ❑eyedrop ❑inhale ❑injection ❑other ______	❑once a day ❑twice a day ❑three times a day ❑four times a day ❑other ______

I attest that the above list is a complete list to the best of my knowledge and ability.

Patient Signature: ___________________________ Date: ________________

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Patient Questionnaire
New Insurance Requirements

VACCINATION SCREENING

Please Answer "Yes" or "No":

Have you ever received a pneumonia vaccine? ❑yes ❑ no

Date if yes: _____

Have you received a flu vaccine for this flu season?
(October 1, 2016 through March 31, 2017) ❑yes ❑ no

Date if yes: _____

Please list your occupation: _____
or check if you are retired: ❑ retired

Please list with whom you live:
- ❑ spouse
- ❑ partner
- ❑ family
- ❑ friends
- ❑ assisted living
- ❑ self
- ❑ other:_____

Patient Name: _____

Signature: _____ Date: _____

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Please list any medical problems that the following family members have or had:

Mother: _____

Father: _____

Please list your current or past medical conditions and illnesses:

_____

_____

_____

_____

_____

_____

_____

Please list your past surgeries:

_____

_____

Patient Name: _____

Signature: _____ Date: _____

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Notice of Privacy Practice Signature Sheet

I have read and understand the DC Retina / Neal Adams MC PC's Notice of Privacy Practice on how DC Retina / Neal Adams MD PC will use my personal information. I give my permission for my personal information to be used in that manner. This signature sheet will remain in my patient chart as a record of acceptance and the Notice of Privacy Practice is for me or my representative to keep for my records.

Patient Name: _____

Signature: _____

Name of Person (if other than patient): _____

Relationship to Patient (if other than self): _____

Date: _____

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also

share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

DC Retina

Neal Adams MD PC

2101 Medical Park Drive, Suite 303

Silver Spring, MD 20902

(301) 754-1200

Fax (855) 673-8462