THE RETINA INSTITUTE
PREMIER RETINAL EYE CARE

New Patient Packet – 6 pages total

PATIENT INFORMATION

Name: First	Middle		Last
Date of Birth	Age	Gender	Race
Street Address			
City	State		Zip
Home Phone	Cell Phone		Other Phone
Social Security #	Email		
Emergency Contact	Relationship / Phone		
Patient Marital Status	Employer / Phone		

INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name: First	Middle	Last
Street Address		
City	State	Zip
Home Phone	Cell Phone	Other Phone
Social Security #	Email	
Employer / Phone		

PRIMARY INSURANCE COMPANY

Company	Policy ID #	Group # □HMO □PPO
Name of Policy Holder	Relationship to Insured	
Policy Holder Social Security #	Policy Holder Date of Birth	

SECONDARY INSURANCE COMPANY

Company	Policy ID #	Group # □HMO □PPO

LOCAL PHARMACY

Name	Phone	
Street Address		
City	State	Zip

MAILORDER PHARMACY

Name	Phone

Referred by: _____ Primary Care Doctor: _____

Signature on File, Assignment of Benefits, Financial Agreement

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to THE RETINA INSTITUTE, for services furnished me by THE RETINA INSTITUTE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. THE RETINA INSTITUTE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services, as determined by the Medicare carrier.

MEDI-GAP: I understand that if a Medi-Gap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to THE RETINA INSTITUTE, or if to me to be forwarded immediately to THE RETINA INSTITUTE.

RELEASE OF INFORMATION: THE RETINA INSTITUTE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to THE RETINA INSTITUTE for reimbursement for services rendered, and (2) any health care provider for continued patient care. THE RETINA INSTITUTE may also disclose on an anonymous basis any information concerning my case. A copy of this authorization may be used in place of the original.

OTHER INSURANCE: I understand that THE RETINA INSTITUTE maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that THE RETINA INSTITUTE has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by THE RETINA INSTITUTE if I belong to a plan that does not contract with THE RETINA INSTITUTE.

NON-COVERED SERVICES: I understand that THE RETINA INSTITUTE's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with THE RETINA INSTITUTE to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by LA PRIMARY CARE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to THE RETINA INSTITUTE for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I agree that any credit card payment dispute must be concluded in favor of THE RETINA INSTITUTE, as non-returnable services have already been rendered and must be paid as agreed here. Any benefits of any type, under any policy of insurance insuring the patient or any other party liable to the patient, is hereby assigned to THE RETINA INSTITUTE. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to THE RETINA INSTITUTE. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____

Signature of Patient/Beneficiary or Authorized Party Date

_____

Printed Patient/Beneficiary Name

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, THE RETINA INSTITUTE originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that THE RETINA INSTITUTE is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that THE RETINA INSTITUTE, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should THE RETINA INSTITUTE, change their notice, they will send a copy of any revised notice to the address I've provided (either U.S. mail, or, if I agree, e-mail).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Acknowledgement of Receipt of Privacy Practices
I have been presented with a copy of THE RETINA INSTITUTE Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law.

_____

Signature of Patient or Authorized Party Date

_____

Printed Patient Name (and that of Authorized Party if applicable)

Medical History

Patient Name: _____ Date: _____

Referred by: _____

Other Eye Doctors seen: _____

All medications (including eye medications):

x_____ Initial if no medicine allergies. All medicine allergies:

Surgeries (including year):

Patient Initials_____

Please check the box under "YOU" if you have the disorder	YOU	FAMILY (blood relatives only)
Diabetes		
High Blood Pressure		
High Cholesterol or Triglycerides		
Auto-Immune Disease such as Lupus, RA, Sarcoid, VKH, Sjogren's, Graves', or other:		
Kidney Disease or Dialysis (please circle)		
Stroke: brain or eye (please circle)		
Asthma or COPD (Emphysema) (please circle)		
Cancer:		
Tuberculosis		
HIV Infection or AIDS		
Heart Disease or Rhythm Disorder (please circle)		
Liver Disease or Hepatitis (please circle)		
Seizure Disorder		
Anxiety or Depression (please circle)		
Sleep Apnea		
Other Full Body Diseases:		
Crossed Eyes		
Glaucoma		
Retinal Detachment		
Macular Degeneration		
Other Eye Diseases:		
Are You Pregnant?		N/A

Review of Systems: Please circle below if symptoms

Fever Weight loss Fatigue Ears Nose Mouth/Throat

Heart Blood vessels Lungs Esophagus Stomach

Intestines Kidneys Bladder Genital system Muscles

Bones Joints Skin Breasts Nervous system

Psychiatric system Endocrine (glandular) system

Blood or Lymph system Allergies or Immune system

Social History: (CHECK IF YES)

Smoke or Quit (please circle)	
Other tobacco use of any type	
Drink alcohol? Drinks/week?	
Drug abuse: now or past	
Exposed to Hepatitis	
Exposed to Tuberculosis	
Exposed to HIV/AIDS	
Eaten raw meats	
Use recreational drugs	
Use stimulants / energy drinks	
Occupation:	

I certify that the above clinical information is accurate and complete:

_____

Signature of Patient or Authorized Party Date

_____

Printed Patient Name (and that of Authorized Party if applicable)

Consent for Examination including Dilating Eye Drops:

I consent to such examination procedures as in the judgment of my physicians may be considered necessary or advisable as long as I am a patient of THE RETINA INSTITUTE. I accept that my treatment and care may be observed and/or aided by physicians and/or other assistants under supervision

I authorize THE RETINA INSTITUTE staff to administer dilating eye drops to me as long as I am a Patient of THE RETINA INSTITUTE.

- Dilating drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye. Dilating drops may blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected.

- Because walking or driving may be difficult immediately after your examination, you should be prepared to have an assistant or driver in case you feel you are unable to walk or drive safely.

- Adverse reactions, such as acute angle-closure glaucoma, may be triggered by dilating drops. This is rare and treatable with immediate medical attention.

Agreement for Continuity of Care:

For my own safety, during the time that I am a Patient of THE RETINA INSTITUTE, I agree that I will consult my Physician here before proceeding with eye-related procedures elsewhere.

_____

Signature of Patient or Authorized Party Date

_____

Printed Patient Name (and that of Authorized Party if applicable)