**Retina Specialists**

**20 West 13th Street**

**New York, NY 10011**

**Tel: (212) 604- 9800**

# Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_ Sex M\_\_\_\_\_ F\_\_\_\_

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone (** **) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_**

**Race: White \_\_\_\_\_ African-American/Black \_\_\_\_\_ American Native \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_ Pacific Islander\_\_\_\_ More Than One \_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_ Refuse to Report \_\_\_\_\_\_\_**

**Ethnicity: Hispanic or Latino \_\_\_\_\_\_\_ Non-Hispanic or Latino \_\_\_\_\_\_\_ Refuse to Report \_\_\_\_\_\_\_**

**Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE**

**Primary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Holder’s DOB \_\_\_/\_\_\_/\_\_\_**

**Secondary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Holder’s DOB \_\_\_/\_\_\_/\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary M.D. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring M.D. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I request that payments of authorized insurance benefits be made either to me or on my behalf to**

**Retina Specialists for any services furnished by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PATIENT/GUARDIAN DATE**

**Notice of Privacy Practices**

**Patient Acknowledgement**

Retina Specialists

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice’s legal duties with respect to my protected health information. The Notice includes:

• A statement that this practice is required by law to maintain the privacy of protected health

information.

• A statement that this practice is required to abide by the terms of the notice currently in effect.

• Types of uses and disclosures that this practice is permitted to make for each of the following

purposes: treatment, payment, and health care operations.

• A description of each of the other purposes for which this practice is permitted or required to

use or disclose protected health information without my written consent or authorization.

• A description of uses and disclosures that are prohibited or materially limited by law.

• A description of other uses and disclosures that will be made only with my written

authorization and that I may revoke such authorization.

• My individual rights with respect to protected health information and a brief description of how

I may exercise these rights in relation to:

· The right to complain to this practice and to the Secretary of HHS if I believe my

privacy rights have been violated, and that no retaliatory actions will be used against me

in the event of such a complaint.

· The right to request restrictions on certain uses and disclosures of my protected health

information, and that this practice is not required to agree to a requested restriction.

· The right to receive confidential communications of protected health information.

· The right to inspect and copy protected health information.

· The right to amend protected health information.

· The right to receive an accounting of disclosures of protected health information.

· The right to obtain a paper copy of the Notice of Privacy Practices from this practice

upon request.

Per the practice’s privacy policies, photographing, video recording and audio recording is strictly prohibited on the premises, except with our prior written consent.

\*Please indicate any person/persons you allow us to discuss your health information with:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Retina Specialists**

*Diseases and Surgery of the Retina and Vitreous*

**CONSENT FOR DILATING EYE DROPS**  
  
Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye.  These drops usually cause blurred vision.  The length of time that vision will be blurred and the degree of eyesight impairment varies from person to person.  It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.  
  
Driving, especially in low-light conditions, may be difficult or impossible after an examination with dilating drops. If possible, you should not drive yourself afterwards.  Instead, we strongly suggest you make alternative arrangements for transportation after your examination.  If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others.  Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light if you do choose to drive.     
  
Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.  
  
You, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Dr. Khadem, Dr. Pieroni and/or his or her other assistants to administer dilating eye drops during the course of your treatment. You understand that these eye drops are necessary to diagnose your condition.  You further understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated and if you do choose to drive, by wearing sunglasses while driving.

Please notify us if you are pregnant.

I am pregnant. I am not pregnant.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(or Patient’s Authorized Representative)

**EMAIL/ELECTRONIC COMMUNICATION CONSENT**

Retina Specialists discourages the use of email to communicate about your medical matters because it is not a completely secure method of communication, information could potentially be sent to the wrong person, may not be the most timely method of communication and it is dependent on technology which may or may not work at all times. However, if you choose to communicate with your provider regarding email, Retina Specialists asks that you acknowledge and consent to the following:

I understand that email communication should not be used for emergencies or for communicating time sensitive information. In the event of a medical emergency I should contact 911 or go to the nearest Emergency Department. To communicate emergent or time sensitive information I should directly contact the office of the healthcare provider.

I understand that email communication will be processed during routine business hours. In the event I do not receive a response, I understand that I should contact the office directly.

I understand that due to situations outside of the control of the physician, clinicians and office practices, internet and email service may be interrupted or not work at any given time. The physicians, clinicians and office practices are not responsible for technical failures. Again, if you do not receive a response to your email, please call the office directly during business hours.

I will not share, distribute, release or sell my healthcare provider’s email address to anyone.

I understand that email communication is not a substitute for medical care and evaluation. I must arrange for an office appointment to assure appropriate care.

I understand that I am to provide my full name and contact information in all emails, e.g., full name, address, phone number(s) on each email.

I understand and accept that my provider may route my email to other members of the staff for informational purposes or for expediting a response. I authorize my provider to send and designate staff to receive and read my email.

At all times, emails originating from the Health System Network, will use proper encryption technologies to prevent interception of emails by inappropriate parties. However, I acknowledge that many commonly used email services are not secure and fall outside the security requirement set forth by Health Insurance Portability and Accountability Act for the transmission of protected information. Therefore, I understand there is a risk that my health information may be obtained by others not affiliated with my provider. I authorize my provider to transmit my personal health information via email even though email may not be secure and private and may be subject to loss or exposure.

I acknowledge and accept that my healthcare provider can terminate email communication services at any time. I understand that I am responsible for notifying the physician if I chose to discontinue email communication or if my email address has changed.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(or Patient’s Authorized Representative)  
Patient Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_