

PATIENT INFORMATION:

First Name		Middle		Last	
Birth Date / /		Age		Gender: MALE FEMALE	
Street Address			City		State Zip
Check if OK for appointment reminders by phone call:		by text:		by email:	
Home Phone ()	Cell Phone ()	Other Phone ()	Social Security # - -		
Next of Kin/Emergency Contact Name		Relationship		Phone # ()	
Patient Marital Status (please circle): Single - Married - Divorced - Widowed - Legally Separated					
Race:		Email:			
Referring Doctor:			Primary Care Doctor:		

INDIVIDUAL RESPONSIBLE FOR PAYMENT:

First Name		Middle		Last	
Street Address			City		State Zip
Home Phone ()	Work Phone ()	Employer		Social Security # - -	

PRIMARY INSURANCE COMPANY

Company		Policy ID #		Group # HMO or PPO	
Name of Policy Holder		DOB		SSN Relationship to Insured	

SECONDARY INSURANCE COMPANY

Company		Policy ID #		Group # HMO or PPO	
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PHARMACY INFORMATION

Pharmacy name, address, and phone # (if using mail order, please include name of company):
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Signature on File, Assignment of Benefits, Financial Agreement

1. **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, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **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, if possible, or otherwise to me.
3. **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, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **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 appear on the above mentioned list.
5. **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.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by THE RETINA INSTITUTE, 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. 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.

Signed: _____
Beneficiary Signature or Authorized Party Date

Beneficiary Name (print): _____

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 THE RETINA INSTITUTE'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.

I understand and accept the terms of this consent.

Signed _____ Date: _____
(If other than patient, please give relationship)

Please print name _____

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

Social History: (CHECK IF YES)

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	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:

Signed: _____ Date: _____
(If other than patient, give relationship)

Please print name _____

Consent for Examination including Dilating Eye Drops:

- I hereby 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 hereby authorize physicians and/or their assistants 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 with Dr. Ebrahim before proceeding with eye-related procedures elsewhere.

Signed: _____ Date: _____
(If other than patient, give relationship)

Please print name _____