Vitreo-Retinal Consultants, Inc.℠

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Dear _____:

Thank you for choosing Vitreo-Retinal Consultants, Inc. for your retinal eye care. In order to expedite your upcoming visit and to more efficiently file your insurance claim(s), we are attaching several forms for you to complete. **Please bring the following:**

- ☐ New Patient Information Form
- ☐ Medications/Allergy List
- ☐ Medical History and Review of Systems Form
- ☐ Dilating Eye Drop Form
- ☐ Notice of Privacy Practices Form
- ☐ Financial Policy Form
- ☐ A Driver/Transport to and from your appointment
- ☐ Your Insurance Card(s) and Photo I.D.
- ☐ Your Eyeglasses
- ☐ Power of Attorney paperwork (if applicable)

with you to your visit on: _____

at: _____ AM / PM

During your visit, we will place dilating drops in your eyes, which will enlarge your pupils and allow the doctor to examine your retina. The drops frequently blur vision, and may make you more sensitive to light. After an examination, your ability to drive safely may be impaired due to the effect of the dilating drops to your vision. Therefore, you should not drive yourself, but make arrangements to be driven to and from your appointments.

For directions and more information on our practice, please visit:
www.vitreo-retinal.com.

Again, we thank you for trusting us with the health of your eyes and look forward to serving you.

Vitreo-Retinal Consultants, Inc.℠

Patient Information

Email Address: _____ **Do you reside in a nursing care facility?**

☐ **YES** ☐ **NO**

PERSONAL INFORMATION — PLEASE PRINT

Last Name: _____ First Name: _____ Middle Initial: _____

S.S. #: _____-____-_____ Date of Birth: ____ /____ /_____ Sex: Male / Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Employer: _____ Occupation (former if retired): _____

Address: _____ Work Phone: (_____)_____

Spouse/Guarantor's Name: _____ Date of Birth: ____ /____ /_____

Employer: _____ Work Phone: (_____)_____

ALTERNATE CONTACT (Family member or friend *NOT* living with you):

Name: _____ Relationship: _____

Phone: (_____)_____ Cell Phone: (_____)_____

We are participating in the government's "Meaningful Use Program", which is intended to improve care coordination and ensure security and privacy provisions for personal health information. You are not required to complete the following THREE questions, but doing so will allow us to have accurate information recorded.

1.) Race (You may select more than one): ☐ Native American/Native Alaskan ☐ Asian

☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

2.) Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **3.) Preferred Language**: _____

INSURANCE INFORMATION (Please bring insurance cards to the front desk)

Primary Insurance: _____ **#** _____ Group #: _____

Name of Policyholder: _____ Social Security **#**_____ D.O.B. _____

Secondary Insurance: _____ **#** _____ Group #: _____

Name of Policyholder: _____ Social Security **#**_____ D.O.B. _____

INSURANCE ASSIGNMENT & RELEASE:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Vitreo-Retinal Consultants, Inc., for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I many have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

Signature: _____ **Appointment Date: _____**

(Patient or Legal Guardian)

Vitreo-Retinal Consultants, Inc.℠

Medical History and Review of Systems (ROS)

In order to provide comprehensive medical care, we ask you to answer the following questions. This information will become part of your confidential medical record. If you do not understand a question, please place a "?" alongside.
PLEASE PRINT. Thank you.

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

YOUR EYE HISTORY

Yes	No	
_____	_____	Macular degeneration
_____	_____	Diabetic eye disease
_____	_____	Glaucoma
_____	_____	Detached/torn retina
_____	_____	Cataracts
_____		R eye cataract surgery (date)
_____		L eye cataract surgery (date)
_____		Other eye conditions
_____		Other eye surgery (date/s)

GENERAL INFORMATION

Place a check if you have the following:

_____ Eyeglasses
_____ Contact lenses
_____ Hearing aid/s
_____ Pacemaker
_____ Dialysis

HEIGHT _____

WEIGHT _____

MEDICAL HISTORY: Do you have, or have you had, any of the following:

Yes	No		Yes	No	
_____	_____	High blood sugar (diabetes)	_____	_____	COPD, asthma, emphysema
_____	_____	Heart disease or heart attack	_____	_____	Dementia/Alzheimer's disease
_____	_____	Abnormal EKG	_____	_____	Arthritis (rheumatoid, osteo, gout etc)
_____	_____	High blood pressure	_____	_____	Liver disease (cirrhosis, hepatitis)
_____	_____	Stroke	_____	_____	Anemia or blood problems
_____	_____	High cholesterol	_____	_____	Kidney disease or stones
_____	_____	Prostate disease or cancer	_____	_____	Other _____
_____	_____	Cancer (type _____)			

SURGICAL HISTORY (Procedure/Year)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY _____ Adopted _____ Unknown

Check if your mother, father, siblings or grandparents have the following:

		Family Member			Family Member
_____	Diabetes	_____	_____	Macular degeneration	_____
_____	Heart disease/attack	_____	_____	Glaucoma	_____
_____	High blood pressure	_____	_____	Detached/torn retina	_____
_____	Stroke	_____			
_____	Cancer (type) _____	_____			

— Over Please —

SOCIAL HISTORY

Do you smoke? Yes ____ No ____ Drink alcohol? Yes ____ No _____

When did you quit? _____

REVIEW OF SYSTEMS: Please complete based on your CURRENT HEALTH STATUS.

Yes	No		Yes	No	
_____	_____	General weakness	_____	_____	Seasonal allergies
_____	_____	Unexplained weight loss/gain	_____	_____	Food allergies
_____	_____	Fatigue	_____	_____	Urinary frequency
_____	_____	Fever	_____	_____	Decreased urination
_____	_____	Pain or tightness in chest	_____	_____	Difficult/painful urination
_____	_____	Rapid or abnormal heartbeat/palpitations	_____	_____	Appetite changes
_____	_____	Varicose veins	_____	_____	Increased thirst
_____	_____	Ankle/leg swelling	_____	_____	Heat intolerance
_____	_____	Shortness of breath with/without activity	_____	_____	Hot flashes
_____	_____	Decreased hearing	_____	_____	Digestive or stomach problems (heartburn etc)
_____	_____	Ringing in the ears	_____	_____	Bowel bleeding
_____	_____	Nose bleeds	_____	_____	Abdominal pain
_____	_____	Dizziness or fainting spells	_____	_____	Nausea
_____	_____	Sinus problems	_____	_____	Post-menopausal
_____	_____	Wheezing	_____	_____	Menstrual irregularities
_____	_____	Chronic or frequent cough	_____	_____	Skin rash
_____	_____	Pain when breathing	_____	_____	Itchy Skin
_____	_____	Difficulty swallowing	_____	_____	Shingles
_____	_____	Easy bruising	_____	_____	Hives
_____	_____	Easy bleeding	_____	_____	Migraines
_____	_____	Enlarged lymph nodes	_____	_____	Frequent or severe headaches
_____	_____	Joint swelling	_____	_____	Fainting spells
_____	_____	Joint pain	_____	_____	Dizziness
_____	_____	Back pain	_____	_____	Memory loss
_____	_____	Muscle pain	_____	_____	Tremors
_____	_____	Muscle weakness/numbness	_____	_____	Hallucinations
_____	_____	Anxiety	_____	_____	Confusion
_____	_____	Depression			

Referring Doctor: _____

Other Eye Doctor: _____

Primary Care Doctor: _____

Specialists (i.e. Cardiology, Endocrinology, Nephrology): _____

_____

_____

This information is given to the best of my knowledge. _____

Patient's signature

v 8-30-17

Vitreo-Retinal Consultants, Inc.℠

Name: _____

Appointment Date: _____

Local Pharmacy Name: _____

Address/City/State: _____

Please list any prescribed or over-the-counter medications and what they are used for, as well as vitamins and supplements; if none please list NONE.

Name	Used For	Dosage	Frequency

Please list any allergies and reaction to any medications, if none please list NONE.

Name of medication:	Type of Reaction:

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Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist 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 may make you much more sensitive to light. Because of this sensitivity, sunglasses should be worn afterwards when your eyes are dilated. Disposable sunglasses are available free of charge at our front desk.

It is not possible for your ophthalmologist to predict how much your vision will be affected. **After an examination, your ability to drive safely may be impaired due to the effect of the dilating drops on your vision. Therefore, you should not drive yourself, but make arrangements to be driven to and from your appointments.** If this is not possible, it is recommended that you wait in the office for your vision to return to normal so that you can drive safely.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare, but a treatable condition taken care of with immediate medical attention, which we are prepared to provide.

I have read and completely understand the above information regarding dilating eye drops. I have been advised that I should not drive, or operate machinery, while my eyes are dilated because my vision, and thus, my driving ability may be impaired. If I choose to drive or operate machinery despite this warning, I assume full responsibility (financial and/or otherwise) for the consequences resulting from this choice. I agree that my doctor, Vitreo-Retinal Consultants, Inc., and its employees are released from all liability resulting from my driving or operating machinery while my eyes are dilated.

I hereby authorize my physician(s) at Vitreo-Retinal Consultants, Inc., and/or such assistants as may be designated by him/her to administer dilating eye drops. Again, these eye dilating drops are necessary to diagnose my condition.

_____	_____
Signature of Patient or Responsible Party	Appointment Date
_____	_____
Practice Representative Initials	Appointment Date

Vitreo-Retinal Consultants, Inc.℠

Notice of Privacy Practices Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to receive a copy of our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that you have had the opportunity to receive our Notice of Privacy Practices. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices, and I have the opportunity to review and receive a paper copy of this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- I have the right to request restrictions to the uses of my information. The Practice does not have to agree to those restrictions, but if we do, we will honor these restrictions.

I authorize Vitreo-Retinal Consultants, Inc. to disclose information regarding my medical condition(s)/treatment(s) to **(please PRINT all name[s] and relationship[s] that apply)**:

☐ My Spouse: _____

☐ My Child(ren): _____

_____

☐ My Parent(s): _____

☐ Other (ie., family member[s] or friend[s] who may be involved in my medical care):

_____

_____

I understand that if I provide the Practice with a secondary contact, the Practice may contact that person with information regarding my appointments.

This Acknowledgement was signed by: _____ (Printed Name)

_____ (Patient Signature)

_____ Appointment Date

Relationship to Patient (if other than patient): _____

Practice Representative Initials: _____

Vitreo-Retinal Consultants, Inc.℠

Financial Policy

Thank you for entrusting Vitreo-Retinal Consultants, Inc. with the health of your eyes. The following is our Financial Policy, which we require all patients to read and sign prior to treatment or surgery. We also require all patients to complete the Personal and Insurance Information sections of our patient registration form.

Patients receiving care at Vitreo-Retinal Consultants, Inc. are responsible for their own medical bill. Payment is expected at the time services are rendered. As with any other business, it is necessary for us to receive payment for our services to ensure we can provide superior quality care as cost effectively as possible.

Insurance:

We understand that many patients have health insurance coverage, and we accept assignment with many insurance plans. When you arrive for each appointment, please be prepared to confirm your insurance coverage by presenting your current insurance card. We will need to scan a copy for our records. We will submit claims for the services you receive to your insurance company. Any balance due after your insurance company has paid their portion or denied payment is your responsibility.

Please be aware that some services may not be covered by your insurance company, or payments may be reduced based on their arbitrary determination of usual and customary rates. We will make every reasonable effort to notify you in advance, if we expect this will be the case. However, your insurance policy is a contract between you and your insurance company, and we cannot be responsible for the coverage decisions of that company. You are responsible for payment regardless of your insurance company's coverage decisions.

Self Pay Patients:

We do provide care for patients who do not carry medical insurance. In this situation, payment is due at time of service.

Medications:

Some conditions may require treatment with medications that may not be covered by insurance. Please note that these drugs are purchased in advance for your care, and we require prompt payment for these services.

All co-pays, co-insurance and deductibles are due at time of service.
We charge a $25.00 fee for all returned checks.

— Over Please —

Vitreo-Retinal Consultants, Inc.℠

Payment Options:

For balances of $300.00 or less:	Pay by cash, check or credit card. We accept Visa, Mastercard, Discover and American Express.
For balances greater than $300.00:	1.) Pay by cash, check, or credit card. We accept Visa, Mastercard, Discover and American Express. 2.) Apply for short-term, interest free financing, with a revolving line of credit through CareCredit. 3.) Apply for long-term, 14.9% fixed interest financing, with a revolving line of credit through CareCredit.

Questions?

If you have questions regarding the Financial Policy of Vitreo-Retinal Consultants, Inc. or need to discuss payment options before the time of service, please contact our Patient Accounts Department between 8:30 a.m. and 4:30 p.m., Monday through Friday at (330) 494-1116 or (800) 438-1169.

I have read the Financial Policy of Vitreo-Retinal Consultants, Inc., and I understand and agree to its terms and conditions.

_____ _____

Signature of Patient or Responsible Party Appointment Date