VIRGINIA RETINA SPECIALISTS

Center for Excellence in Vitreo-Retinal Surgery and Retinal Diseases

Patient Name: _____ **Date of Birth:** _____ /_____/_____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

Gender: □ **Male** □ **Female** **Marital Status:** □ **Single** □ **Married** □ **Widowed** □ **Divorced** □ **Separated**

Emergency Contact Person: _____ **Cell Phone:** _____

Is your current address the same address listed on your photo ID? □ **Yes** □ **No (If no, please complete the following): Street Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Family Physician/Internist:_____ **Phone:**_____

Optometrist:_____ **Phone:** _____

Ophthalmologist:_____ **Phone:** _____

Referring Doctor (if different):_____ **Phone:** _____

If you have Medicare please complete the following information:

Member ID:_____

Hospital (Part A) Effective Date: _____ **Medical (Part B) Effective Date:** _____

Select the Correct Entitlement Reason: Age____ Disability ____ End Stage of Renal Disease _____

**** Please provide ALL insurance information to the front desk.**

**** If you have more than one insurance, be sure to provide ALL insurance cards.**

I hereby authorize Virginia Retina Specialists (VRS) to bill my insurance (which may include release of medical information to process this claim). I also authorize payment to be made directly to VRS. In addition, if my account is forwarded to an outside collection agency for collection of a past due balance, I will be responsible for the collection fees incurred by VRS to said outside collection agency.

YOUR SIGNATURE IS REQUIRED BELOW

*** Signature:** _____ ***Date:** _____

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MEDICATIONS: List all current medications (prescription and over-the-counter): ☐ SEE ATTACHED LIST ☐ *NOT TAKING ANY MEDICATIONS*		**OCULAR MEDICATIONS:** (i.e. eye drops: Timolol, Cosopt, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: Do you have allergies to any medication? ☐ YES ☐ NO If YES, list the medication(s) and reactions:

_____ _____

MEDICAL HISTORY	YES	NO	FAMILY HISTORY	YES	NO
Arthritis			Retinal Detachment		
Asthma			Macular Degeneration		
Diabetes: ☐ Type 1 ☐ Type 2			Retinal Disease		
* Insulin dependent:			Diabetes		
Heart Disease			Heart Disease		
High Blood Pressure			High Blood Pressure		
Cancer			Cancer		
Thyroid Disease			Thyroid Disease		
Stroke			Stroke		
Hay fever or Sinus Disease			Other:		

SOCIAL HISTORY	YES	NO	EXPLANATION:	YES	NO
OCCUPATION:			Are you actively working?		
Marital Status:			☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated		
Do you drive?					
Do you currently smoke?			How many packs per day?		
Have you ever smoked?			What type? (cigarettes, pipe, chewing, smokeless, etc.)		
Do you drink alcohol?			How many drinks per week?		
Have you ever had a history of STDs)? (gonorrhea, syphilis, HIV, etc.)			Was treatment was received?		
Have you had any falls in the last year?			How many falls?		

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Eye Surgeries: (e.g. cataract surgery, glaucoma surgery, retinal detachment surgery, LASIK, etc.)
Other Surgeries: (appendectomy, tonsillectomy, colon surgery, etc.)

REVIEW OF SYSTEMS	**YES**	**NO**	Do you ***currently*** have any problems in the following areas? If yes, please explain.
GENERAL (fever, weight loss, etc.)			
EYES (blurred vision, double vision, distortion of vision, floaters, etc.)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat, etc.)			
CARDIOVASCULAR (chest pain, arrythmias, high blood pressure, etc.)			
RESPIRATORY (cough, shortness of breath, asthma, etc.)			
GASTROINTESTINAL (nausea, vomiting, diarrhea, loss of appetite, etc.)			
GENITOURINARY (frequent urination, kidney stones, blood in urine, etc.)			
MUSCULOSKELETAL (joint pain, muscle weakness, etc.)			
SKIN (rash, skin cancer, warts, etc.)			
NEUROLOGICAL (headaches, weaknesses, paralysis, seizures, etc.)			
PSYCHIATRIC (depression, anxiety, memory loss, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
HEMATOLOGIC (anemia, bleeding or bruising tendencies, etc.)			
ALLERGIC/IMMUNOLOGIC (hay fever, redness, recurrent infections, etc.)			

THIS FORM WAS COMPLETED BY: ☐ PATIENT ☐ FAMILY MEMBER ☐ STAFF TECHNICIAN ☐ OTHER: _____

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LANGUAGE, RACE, ETHNICITY QUESTIONNAIRE

This information is being requested by the federal government and will not be shared for non-medical use. You are free to decline disclosure of this information.

PREFERRED LANGUAGE	
□ English	□ Armenian
□ Chinese	□ Arabic
□ French	□ German
□ Greek	□ Hindi
□ Hebrew	□ Italian
□ Persian	□ Polish
□ Japanese	□ Javanese
□ Portuguese	□ Russian
□ Spanish	□ Turkish
□ Urdu	□ Vietnamese
□ Other:	

RACE	
□ American Indian or Alaskan Native	□ Armenian
□ Black or African American	□ Native Hawaiian or other Pacific Islander
□ East Asian	□ South Asian
□ White	□ Unknown

Ethnicity	
□ Hispanic or Latino	□ Not Hispanic or Latino
□ Unknown	

□ **I DECLINE TO DISCLOSE THE ABOVE INFORMATION**

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Insurance Billing

I hereby authorize Virginia Retina Specialists to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Virginia Retina Specialists all the money to which I am entitled to medical and/or surgical expenses related to the service reported. I understand that I am financially responsible for said practice for charges not covered by this assignment.

NO INSURANCE: Payment is due at the time of service; however, we do allow financial arrangements. Non-paid accounts are referred to a collection agency ninety (90) days after the first charge.

INSURANCE: Co-payments, deductibles, or non-covered charges are due at the time of service. Non-paid accounts may be referred to a collection agency one hundred and twenty (120) days after the first charge. We may bill your insurance for you; however, this does not release your responsibility for payment on any charges not paid by your insurance.

Primary Insurance: _____ **Member ID/ Policy number:** _____

Effective Date: _____

Secondary Insurance: _____**Member ID/ Policy number:** _____
Effective Date: _____

Tertiary Insurance: _____**Member ID/ Policy number:** _____
Effective Date: _____

PATIENT SIGNATURE: _____

PATIENT NAME: _____ **DATE:** _____

**** If you are <u>NOT</u> the primary policy holder, please complete the following:**

□ Primary □ Secondary □ Tertiary

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

Relationship to patient: _____

Policy Holder Address: □ same _____

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Patient Initials: _____

NOTICE TO ALL VRS PATIENTS

Please read carefully and initial on the line

____ If your insurance plan includes an annual deductible, payment will be expected on date of visit for the services incurred until deductible is met.

____ Co-payment is due at the time of service.

____ If referral or authorization is required, it is the responsibility of the patient to have required authorization issued from their health maintenance organization for all services to be rendered.

____ If Authorization is not obtained, the patient will be responsible for all charges incurred.

____If your insurance does not cover/approve a certain service/procedure, you are responsible to pay for this service/procedure.

____ A no-show fee of $50.00 will be billed to you if you do not give at least a 24-hour notice prior to cancellation of your appointment. This fee is not covered by your health insurance.

____ I hereby authorize the doctor and his/her assistants to administer dilating eye drops, which are necessary to diagnose my condition. The eye drops will blur my vision for a length of time, often for 3-4 hours and occasionally longer in some individuals. An adverse reaction, acute angle-closure glaucoma, may be triggered by dilating drops. This is extremely rare and is treatable with immediate medical attention.

Do you authorize our practice to send electronic statements via text message to the mobile number we have on file?

____Yes

____No

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(HIPAA)

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice of our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice. Every patient must receive our new Privacy Notice and execute anew Consent Agreement before this office may use your information for treatment, payment, or other health care operations (TPO). Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual."

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 that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

DISCLOSURE TO FAMILY / FRIENDS:

I authorize Virginia Retina Specialists to disclose medical or financial information to the following individual(s):

Name	Relationship	Telephone number
Name	Relationship	Telephone number

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TRANSFER OF MEDICAL RECORDS TO OTHER MEDICAL PRACTICES: Our practice will transfer or release your medical records to another healthcare provider **only upon your written request or authorization**. We do not routinely send records to outside practices unless you have provided us with explicit permission to do so.

All of these disclosures could occur previously under former laws and regulations; however, the Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principles. On some occasions, we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another healthcare provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard. Although the law requires a signed and dated Privacy Notice this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner. It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years. In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your PHI. This office continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice.

_____ _____

Patient Signature Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

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How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

OFFICEADMIN@VARETINASPECIALISTS.ORG OR CALL (703) 288-9001