Patient ID _____
Updated: 05/10/2016

RETINA ASSOCIATES OF FLORIDA
Diseases & Surgery of the Retina & Macula

PATIENT DATA SHEET – PLEASE COMPLETE IN FULL AND SIGN

Last Name: _____ First Name: _____ MI:_____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Email: _____

Second Address: _____ From: _____To: _____

City: _____ State: _____ Zip: _____

Sex: M / F Date of Birth: _____ Social Security No.:_____

Do you currently live in a Skilled Nursing Facility or are you currently under the care of Hospice?
____ Yes ___ No If yes please name the facility: _____

How did you hear about RAF? (Please circle one):

Doctor Referral: _____ Phone: _____

Friend / Internet / Seminar / TV / Newspaper / Other: _____

Primary Care Doctor _____ Phone _____

Spouse / Legal Guardian: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone No.: _____

Are you Employed? ____ Yes ____ No If yes, where? _____

Work Phone: _____

Primary Insurance: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Name of Insured: _____ Group #: _____

Responsible Party: _____ Relationship:_____

1. Race

____ American Indian or Alaska Native	____ Asian
____ Black or African American	____ Native Hawaiian or Other Pacific Islander
____ White / Caucasian	____ Declined to Provide
____ Hispanic / Latino	____ Other

2. Ethnicity

____ Hispanic / Latino	____ Non-Hispanic / Latino
____ Declined to Provide	____ Other

3. Language: ___ English ___ Spanish ___ Other ___ Declined to Provide

In order to protect your health information, please answer the following questions:

1. Please list any family members or persons, if any, whom we may inform about your general medical condition and your diagnosis.
   _____ Relationship_____
   _____ Relationship_____
   _____ Relationship _____
2. May confidential messages be left on your home answering machine or voicemail? Yes ___ No____
3. May we communicate with you via email? Yes _____ No_____

- ✓ I, the undersigned, have insurance with the above named company (ies) and I assign directly to Retina Associates of Florida, P.A. all benefits payable to me for services rendered. If Retina Associates of Florida, P.A. is a participating provider for my insurance company, I agree to pay any charges deemed as my responsibility by my insurance company. I authorize the release of any protected health information that is necessary to process my insurance claim.
- ✓ I, the undersigned, hereby authorize any physician who has examined me to release any and all protected health information and medical records to Retina Associates of Florida, P.A.
- ✓ I, the undersigned, hereby authorize Retina Associates of Florida, P.A. to provide and acquire medical information for patient care, patient follow-up and/or anonymous release for clinical study purpose.
- ✓ I, the undersigned, hereby authorize examination and treatment as deemed necessary or desirable by my attending physician including, but not limited to topical and systemic medication, fundus photography, fluorescein angiography, indocyanine green angiography, pneumatic retinopexy, laser therapy, cryotherapy, periocular injections, retrobulbar injections performed by the doctors and/or other qualified designates of Retina Associates of Florida, P.A. The risks, benefits and alternatives will be explained to me prior to the performance of any surgical procedures or invasive tests.
- ✓ I understand and have been provided a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures.
- ✓ Patients that contact our office or send inquiries via email should be advised that email messages are not a guaranteed confidential communication as they may be intercepted or read by unauthorized persons.

Signature: _____ Date:_____

Patient ID _____

MEDICAL HISTORY AND INFORMATION

Please fill out completely

PATIENT HISTORY: Please check the appropriate choice of the medical problems that you have:

Recent weight loss	Yes/No	Loss of appetite	Yes/No	Stroke/TIA	Yes/No
Fever	Yes/No	Abdominal pain/heartburn	Yes/No	Head Injury	Yes/No
Headaches	Yes/No	Peptic ulcer	Yes/No	Confusion/memory loss	Yes/No
Eye injury/disease	Yes/No	Nausea/Vomiting	Yes/No	Nervousness	Yes/No
Do you wear glasses	Yes/No	Blood in urine	Yes/No	Depression	Yes/No
Blurred/double vision	Yes/No	Kidney stones	Yes/No	Diabetes	Yes/No
Glaucoma	Yes/No	Female #pregnancies _____ _____#miscarriages _____		What age diagnosed w/ diabetes? _____	
Hearing loss/ringing	Yes/No			Hemoglobin A1c_____	
Nose bleeds	Yes/No	Joint pain	Yes/No	Thyroid Disease	Yes/No
Swollen glands in neck	Yes/No	Back pain	Yes/No	Bleeding/bruising	Yes/No
High Blood Pressure	Yes/No	Difficulty walking	Yes/No	Anemia	Yes/No
(controlled or uncontrolled) Duration _____	Yes/No	Rash/Itching	Yes/No	Enlarged lymph glands	Yes/No
Chest pain/angina	Yes/No	Varicose veins	Yes/No	Other Disease or Illness	
Heart palpitation	Yes/No	Frequent Headaches	Yes/No	_____	
Shortness of breath	Yes/No	Convulsions/Seizures	Yes/No	_____	
Swelling feet/ankles	Yes/No	Tremors	Yes/No	_____	
Asthma/wheezing	Yes/No	Paralysis	Yes/No		

Please list any eye surgery or laser surgery, including dates and physician's/surgeon's name.

Please list all medications that you take, including eye drops:

Medication **Dose** **Directions**

Please list any allergies to medications that you may have:

Please list all major surgeries, including approximate dates:

Family History:

Please check the appropriate choice if ***anyone in your immediate family*** has had the following conditions:

____Macular Degeneration ____Diabetes ____Cancer

____Retinal Detachment ____Heart Disease ____Glaucoma

Social History:

Do you smoke? __ Yes __ No If yes, how much_____

Do you drink alcohol? __ Yes __ No If yes, how much_____

Any history of drug abuse? __ Yes __ No

Do you live _____ Alone _____ With Spouse_____ Other

Do you work? ___ Yes _____ No _____ Retired Occupation

Patient ID _____

RETINA ASSOCIATES OF FLORIDA
Diseases & Surgery of the Retina & Macula

FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help ensure this, we have established this Financial Policy which contains our requirements for payment of our services and applies to services provided by Retina Associates of Florida at all locations at which it sees patients. **If you are unable to comply with this policy at the time of service your appointment may be rescheduled.**

Patients With Health Insurance

If you have health insurance, for which we are a provider, and you provide us with complete and accurate information, it is our policy to file your insurance claim as a courtesy. In return, we ask that you pay, at the time you check in, any co-pay, cost-share, deductibles and patient balances.

If you elect to have a procedure deemed "non-covered" by your insurance company, you will be responsible for the costs associated with it. **Please read Patient Without Health Insurance for payment expectations.**

If payment from your insurance carrier is not received within 45 days, we may hold you responsible for the full balance.

Patients Without Health Insurance or With Health Insurance For Which We Are Not Providers

If you do not have insurance, or if we are not a provider for your insurance plan, payment in full is due on the day of service as follows:

- **Office Visits:** We will ask you to pay the total charges for services provided on the day of service.
- **In-Office Procedures:** We will ask you to pay the full amount due for in-office procedures at check out. We will explain the cost of all procedures prior to providing services.
- **Non-Emergency Surgery:** Payment is due no later than the day before surgery is performed

Patients Who Miss Scheduled Appointments	**Patients Who Miss AVASTIN INJECTION Appointments**
If you need to cancel or reschedule your appointment when you receive the reminder call, you should select that option. **If you do not cancel or reschedule your appointment within 24 hours of the appointment date and time, a $25 charge will be posted to your account.**	If you need to cancel or reschedule your appointment when you receive the reminder call, you should select that option. **Avastin requires a separate prescription for each patient that can only be used for that patient. If you cancel or reschedule your appointment and the prescription expires, a $125 charge will be posted to your account.**

REFUND POLICY

Refunds

We research any credits and overpayments and refund amounts due to the appropriate payor. If you are due a refund, we will issue your check in a timely manner after we are certain final payment has been made.

It is our policy to hold refunds for less than $10 on your account for your next visit. If you're not leaving the practice or not scheduled to come back within six month, you may ask for a refund, but it is your responsibility to contact our billing department to request your refund.

Dealing with insurance companies is sometimes confusing and almost always complicated. If you have any questions about our Financial Policy or about a refund that you believe is due or a refund check you receive, please call our Billing Department for assistance at 813-875-6373.

Signature: _____ Date:_____

I hereby acknowledge that I have read and understood the Financial Policy for Patient Services and Refund Policy of Retina Associates of Florida.

RETINA ASSOCIATES OF FLORIDA
Diseases & Surgery of the Retina & Macula

Patient ID _____

HIPAA NOTICE OF PRIVACY PRACTICES

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information (PHI) and electronic protected health information (EPHI).
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

For Treatment. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose PHI so we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so they will pay for your treatment.

For Health Care Operations. We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you via email newsletters, which may be administered by third party vendor . In accordance with the Telephone Consumer Protection Act, we are notifying you that you will receive an automated telephone call, on the land line or cell phone provided by you, to remind you of upcoming appointments and recall appointments.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose PHI for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected PHI that directly relates to that person's involvement in your health care. 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.

Restriction of certain disclosures of PHI to a health plan. You have the option to restrict disclosure of PHI to a health plan if you pay out-of-pocket costs in full for the healthcare item or service.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Fundraising Communications. You have the option to opt out of receiving fundraising communications from us which may be sent, from time to time, to make you aware of opportunities to support efforts related to improving the diagnosis and treatment of diseases of the retina and macula.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes (where appropriate)
2. Uses and disclosures of Protected PHI for marketing purposes and fundraising communications; and
3. Disclosures that constitute a sale of your Protected PHI.

Other uses and disclosures of Protected PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our HIPAA Compliance Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this PHI, you must make your request, in writing, to Retina Associates of Florida. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected PHI in the form or format you request, if it is readily producible in such form or format. If the Protected PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this

form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Retina Associates HIPAA Compliance Officer at 602 S MacDill Avenue, Tampa, FL 33609-4614.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Retina Associates HIPAA Compliance Officer at 602 S MacDill Avenue, Tampa, FL 33609-4614.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Retina Associates HIPAA Compliance Officer at 602 S MacDill Avenue, Tampa, FL 33609-4614. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Retina Associates HIPAA Compliance Officer at 602 S MacDill Avenue, Tampa, FL 33609-4614. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Retina Associates HIPAA Compliance Officer at 602 S MacDill Avenue, Tampa, FL 33609-4614. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD AND AGREED TO THE TERMS AND CONDITIONS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient Signature Date

***Right to a Paper Copy of This Notice*. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.**

11/01/2015