RETINA ASSOCIATES OF FLORIDA, P.A.
Diseases and Surgery of the Retina and Macula

PATIENT DATA SHEET – PLEASE COMPLETE IN FULL AND SIGN

Last Name: _____ First Name: _____ MI:_____

Address: _____

City: _____ State:_____ Zip:_____

Second Address: _____ From: _____To: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

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: _____

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

Spouse / Legal Guardian: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone No.: _____

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

Work Phone: _____ Email Address: _____

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

Friend / Internet / Phonebook / Radio / Newspaper / Other: _____

My doctor referred me: Dr. _____ Phone: _____

Primary Care Doctor / Specialist: _____ 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	____ No Race Selected

2. Ethnicity

____ Hispanic / Latino	____ Non-Hispanic / Latino
____ No Ethnicity Selected	____ Declined to Provide

3. Language: ___ English ___ Spanish ___ Other ___ No Language Selected ___ 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:_____

RETINA ASSOCIATES OF FLORIDA, P.A.
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FINANCIAL POLICY FOR PATIENT CARE SERVICES

Thank you for choosing Retina Associates of Florida. Our goal is to provide patients with the highest quality health care. To help ensure this, we have established this Financial Policy, which contains our requirements for payment of our services. You can assist us in keeping costs down by ensuring we are reimbursed for services in a timely manner. If you have any questions regarding this policy, please feel free to call our Billing Manager at 875-6373, extension 226. **If you are unable to comply with this policy at the time of service your appointment may be rescheduled.**

Usual and Customary Rates: Our practice is committed to providing quality, affordable care. Our charges are within what is usual and customary for our geographic area. However, you are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Patients With Health Insurance

If you have health insurance and you provide us with complete and accurate information, it is our policy to file your insurance claim as a courtesy to you. 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. When we receive payment from your insurance company, we will bill you for any remaining portion of our charge(s).

We make every effort to collect benefits from insurance carriers. Although most insurers make payment in a timely manner, we may ask you to contact your insurance company when payment is not made within a reasonable time period.

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

Please make certain we always have current information about you and your insurance coverage.

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.
- **Surgery and In-Office Procedures:** We will ask you to pay the full amount due for surgeries and in-office procedures as follows:
  - **In-Office Procedures:** Full payment is due on the day the procedure is performed.
  - **Non-Emergency Surgery:** Payment is due no later than the day before surgery is performed.

Patients Who Miss Appointments

Appointment times are in great demand and we manage our schedules very carefully to schedule patients at times convenient to them. We will call you the day before each appointment to remind you of the time. If you are unable to keep an appointment, we prefer that you notify us at least 24 hours in advance.

This way, we can reschedule your appointment and make that time available to another patient.

If you miss more than three appointments during one month and do not notify us, we may charge you a $25 fee.

We want your experience to be a pleasant one! Please do not hesitate to call us if you have any questions or concerns.

I hereby acknowledge that I have read and understood the Financial Policy of Retina Associates of Florida, P.A. and agree to comply with all aspects of the policy that pertains to me.

Signed _____ Date _____

RETINA ASSOCIATES OF FLORIDA, P.A.
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REFUND POLICY

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 875-6373.

Patient Payments

If we are a provider for your insurance company, at the time you check in, you will be asked to pay any co-pay, cost-share, co-insurance, deductible and balance due. After your visit is complete, we file a claim with your insurance company.

If we are not a provider for your insurance plan we expect payment in full on the date of service. As a courtesy to you, we file a claim with your insurance company. Since we do not accept assignment, payment should be sent directly to you.

Insurance Company Payments

Once a claim has been filed, it is up to the insurance company to determine when, how much and to whom payment will be made. In some cases, an insurance company will respond promptly and pay our practice within as little as three weeks with one check.

In other cases, it could take as much as a year to receive payment from an insurance company, depending on the type of services provided, other claims that have been filed on your behalf and the insurance company's policy, at a given point in time, for reimbursement.

We sometimes receive multiple checks for one patient's claim over an extended period of time. Whenever we receive what we believe is partial payment we research the matter to determine if that is all the insurance company will pay or if they are making multiple payments.

There are also times when the insurance company determines that it will not make any payment at all.

As you can imagine, it is sometimes difficult to determine exactly when an insurance company has made its final payment on a claim. For this reason, we are careful not to take any action regarding refunds until we have some assurance that final payment has been made. Once we believe final payment has been made, we use the following guidelines for making refunds.

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 timely.

I hereby acknowledge that I have read and understood the Refund Policy of Retina Associates of Florida, P.A.

_____ _____

Patient Signature Date

RETINA ASSOCIATES
OF FLORIDA, P.A.
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MEDICAL HISTORY AND INFORMATION

Please fill out completely

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

Recent weight change	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_____		(insulin dependent, no insulin)	
Hearing loss/ringing	yes/no	#miscarriages_____		duration of diabetes_____	
Nose bleeds	yes/no	Joint pain	yes/no	Hemoglobin A1c_____	
Swollen glands in neck	yes/no	Back pain	yes/no	Thyroid disease	yes/no
High Blood Pressure	yes/no	Difficulty walking	yes/no	Bleeding/bruising	yes/no
(controlled or uncontrolled)		Rash/Itching	yes/no	Anemia	yes/no
duration_____		Change in skin color	yes/no	Enlarged lymph glands	yes/no
Chest pain / angina	yes/no	Varicose veins	yes/no		
Heart palpitation	yes/no	Frequent headaches	yes/no	OTHER DISEASE OR ILLNESS:	
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:

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 _____ _

RETINA ASSOCIATES OF FLORIDA, P.A.
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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE RETINA ASSOCIATES HIPAA COMPLIANCE OFFICER AT 602 S. MACDILL AVENUE, TAMPA, FL 33609-4614.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information (PHI)
- 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

The following describes the ways we may use and disclose PHI that identifies you ("PHI"). Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our HIPAA Compliance Officer.

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.

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.

SPECIAL SITUATIONS

As Required by Law. We will disclose PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our Business Associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to contact you on our behalf regarding educational events we sponsor or participate in. All of our Business Associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

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, P.A.. 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.

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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.tamparetina.com. You can obtain a paper copy of this notice by asking any Front Desk member or Staff member.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

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**.

PLEASE SELECT THE OPTION YOU PREFER FOR RECEIVING MARKETING INFORMATION FROM RETINA ASSOCIATES

____ **YES,** I want to receive marketing information from Retina Associates of Florida, P.A. about its services and other educational information related to the diagnosis and treatment of diseases of the retina and macula.

____ **NO,** I do not want to receive marketing information from Retina Associates of Florida, P.A. about its services and other educational information related to the diagnosis and treatment of diseases of the retina and macula.

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

_____ _____

Patient Signature Date