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

Patient Name: _____

New Patient Data Sheet
Please complete IN FULL and SIGN. Thank you!

First name: MI: Last Name:		
Date of Birth:	SSN#:	Sex: M / F
Address:		
City:	State:	Zip:
Home phone:	Cell phone:	Email:
Secondary Address:		
City:	State:	Zip:

Are you currently under Hospice care or living in a Skilled Nursing Facility? Yes / No
If applicable, please provide name and phone number of the facility:

How did you hear about our practice? Please circle one.	
Doctor Referral (Name & Location):	Phone:
Friend / Internet / Insurance / Second opinion / Former established patient / Other:	

Primary Care Physician (First and Last Name):	
PCP Phone:	Office Location:

Primary Insurance:	Policy #:
Name of Insured:	Group #:
Secondary Insurance:	Policy #:
Name of Insured:	Group #:
Responsible Party:	Relationship:

Patient Name: _____

Emergency Contact Name:	
Emergency Contact Phone:	Relationship:
Designating an emergency contact does not give us permission to discuss your medical information with them. To allow this, please add their name to the HIPPA Contact Authorization section below	

HIPAA Contact Authorization: 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 diagnosis.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

2. May confidential messages be left on your voicemail? Yes / No
3. May we communicate with you via text message? Yes / No
4. 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 Name: _____

Financial Policy for Patient Care Services

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

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.

Patients Who Cancel or Reschedule Surgeries

For patients who cancel or reschedule the same surgery for a non-emergent reason more than twice, a $75 charge will be posted to your account. **For any same day surgery cancellations, a $250 fee will be posted to your account.** This fee will be due prior to rescheduling your surgery if you elect to proceed.

Patient Name: _____

Forms and Medical Records

Forms greater than a single page document to be completed by physician(s), will incur a $25.00 service fee. There is also a standard fee for medical records in the amount of $1.00 per page up to 25 pages and $0.25 cents per page after. Records can also be copied on a thumb drive for a fee of $25.00.

Refund Policy

Dealing with insurance companies is sometimes confusing and almost always complicated. 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 months, you may ask for a refund, but it is your responsibility to contact our billing department to request your refund.

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.

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.

<u>Complaints:</u>

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 hereby acknowledge that I have read, understood, and agreed to the terms and conditions described in this notice of privacy practices.

Signature:	Date:

Patient Name: _____

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

Authorization for Release of Confidential Information
Fax (813) 877-2614 Phone (813) 875-6373

I, _____ DOB ____/____/_____, hereby authorize Retina Associates of Florida, LLC to release or obtain the following medical information:

☐All Records
☐Laboratory/Pathology Records
☐X-ray/Radiological Records
☐Other (describe specifically) _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	

For the purpose of_____

I understand that this consent is revocable upon written notice to the center, except to the extent that action by the center has already taken place this authorization. Retina Associates of Florida is released from all legal liability that may arise from the release of the information. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR, Part 2) prohibits making any further disclosure of the information without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Date	Patient Signature
Patient DOB	Parent, Legal Guardian, or Other Authorized Representative

Space below is for office use ONLY

Records Released (specify):		
Mailed / Faxed (circle)	Date:	By:

Patient Name: _____

Patient Medical History

Please check the ☐ box next to all conditions that apply to you CURRENTLY. This includes conditions well controlled on medication. PLEASE COMPLETE TO THE BEST OF YOUR ABILITY		
☐ Recent weight loss/gain	☐ Swelling of hands/feet	☐ Tremors
☐ Fever/chills	☐ Shortness of breath	☐ Paralysis
☐ Headaches/migraines	☐ Asthma	☐ Stroke/TIA
☐ Eye disease or injury:	☐ Pulmonary disease	☐Head injury
	☐ Loss of appetite	☐ Parkinson's disease
☐ Wear glasses/contacts	☐ Abdominal pain/heartburn	☐ Multiple sclerosis
☐ Hearing loss	☐ Nausea/vomiting	☐ Confusion/memory loss
☐ Nose bleeds	☐ Kidney disease	☐ Anxiety/depression
☐ Cancer	☐ Kidney stones	☐ Diabetes:
If yes, where?	*Females* # pregnancies # miscarriages	Type 1 ***OR*** Type 2
☐ Cardiovascular disease	☐ Hormone replacement therapy	What age were you diagnosed?
☐ Hypertension	☐ Seasonal allergies	Most recent HgbA1c or fasting blood sugar
☐ Controlled	☐ Autoimmune disease	☐ Thyroid disease
☐ Uncontrolled	☐ Rheumatoid arthritis	☐ Bleed or bruise easily
What age were you diagnosed?	☐ Osteoarthritis	☐ Anemia
☐ Chest pain/angina	☐ Difficulty walking	☐ High Cholesterol
☐ Palpitations	☐ Seizures	☐ Blood Clots
Please list any other medical conditions:		

Pharmacy Name: _____ Pharmacy phone number: _____
Pharmacy Address (street address or cross streets):_____

Patient Name: _____

Medication List

Please include dosages if available.

Medication Allergies:

Social History

Do you smoke/vape? Yes / No	Have you ever smoked? Yes / No	*If yes*, when did you quit?
Do you drink? Yes / No	*If yes*, please specify how much/often:	
Do you have a history of illicit drug use? Yes / No		

Family History

Please check the ☐ box if anyone in your IMMEDIATE FAMILY (mother, father, or siblings) has these conditions.

☐ Macular Degeneration	☐ Glaucoma	☐ Diabetes
☐ Retinal Detachment	☐ Cancer	☐ Heart Disease

Surgical History

Please list any EYE SURGERIES you have had, including dates/doctors if available:

Please list any other major surgeries:
