

WELCOME TO OUR PRACTICE

This packet of information contains the necessary paperwork that will need to be completed prior to your visit. **Please bring all enclosed items, your insurance card, form of photo ID, co-payments and referrals** if needed with you to your scheduled appointment.

The following is a checklist of the items contained in the packet:

1. **Things to Note When Coming to Our Office** -This form lets you know what to expect during your visit.
2. **Patient Information Form** – Please complete all questions so you can be properly registered in our system.
3. **Initial Medical History (two (2) page form)** – This form provides a brief synopsis of your current medical health
4. **Medication List** – Use this form to list all medications, vitamins and supplements you are taking
5. **Notice of Privacy Practices** – This notice describes how medical information about you may be used and disclosed.
6. **Notice of Privacy Practices Acknowledgement** - This form is acknowledgment of protected health information and allows you to designate others to have access to your health information. If you decide not to designate a representative on the bottom of the form, we will only be able to talk to the patient for all issues. **This form must be signed in two places.**
7. **Consent for Examination and Information Regarding Dilating Eye Drops** – This form gives your consent to the examination and acknowledgement that both eyes will be dilated for the examination. **This form must be signed in two places.**
8. **Signature of File, Assignment of Benefits, Financial Agreement Form** – This form is acknowledgement that you are responsible for payment of services rendered not covered by your insurance. Form must be signed even if you do not have Medicare. **This form needs to be signed on the bottom.**
9. **Professional Courtesy Copays and No-Show Policies** – This letter provides our policy on professional courtesy and collection of copayments. Also, our No Show Policy charges a \$50.00 (no show fee) if you fail to provide at least a 24 hour notice of appointment cancellation and are unable to keep your appointment.

THINGS TO NOTE WHEN COMING TO OUR OFFICE

You will be at our office for approximately 2-3 hours and longer if you have procedures done the same day.

You will need a driver to bring you to your appointment and to return you home. Your pupils will be dilated in both eyes leaving your close-up vision blurry for approximately 3-4 hours after the exam. The Physician you are scheduled to see may elect not to have the person accompanying you remain in the exam room during a procedure.

PLEASE BRING THE FOLLOWING WITH YOU:

- A list of medications that you currently take along with the dosages.
- A list of any surgeries that you have had.
- Please bring your glasses. In addition, bring a pair of sunglasses or clip-ons if you have them.
- Please bring your insurance cards, form of photo ID, copayment and referral if applicable.

IF YOU ARE A DIABETIC, PLEASE BRING A SNACK WITH YOU!!!

INSURANCE:

We participate with most insurance companies and will submit all claims to any insurance on your behalf. Please check with our front desk to confirm our participation.

Some of the most popular insurers we participate with are listed below:

- Aetna
- BlueCross BlueShield of WNY
- Empire Plan
- Fidelis
- GHI
- Independent Health
- Medicaid
- Medicare
- United Healthcare
- Univera

If you have any questions regarding anything prior to your appointment, please contact our office and we will be happy to assist you.

PATIENT INFORMATION

Appointment Date: _____ Social Security Number: _____

Patient Name: _____
(Last) (First) (Middle)

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

Home phone: _____ Cell phone: _____ Work phone: _____

Date of Birth: _____ Age: _____ Sex: _____ Male _____ Female

Marital Status: _____ Email: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Ethnicity (Please check one) Race (Please check one)

- Hispanic Origin American Indian or Alaskan Native Black/African American
 Not Hispanic Origin Native Hawaiian or Pacific Islander White
 Patient Declined Asian Patient declined

Preferred Language: _____ Patient declined to answer

PROVIDER INFORMATION

Referring Physician Name: _____ Phone #: _____

Address: _____

Primary Care Physician Name: _____ Phone #: _____

Address: _____

Other Physician Name: _____ Phone #: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Tertiary Insurance: _____ ID #: _____ Group #: _____

Subscriber Social Security Number: _____ Subscriber Date of Birth: _____

PHARMACY INFORMATION

Pharmacy: _____ Phone: _____

(Name / Address)

Initial Medical History

Name _____ Date _____

Date of birth _____ Date of last eye exam _____

List any **medications** you currently take [prescriptions, and over-the-counter]

Do you have **allergies** to any medications? YES NO
 If YES, list the medications:

List all **major illnesses** [glaucoma, diabetes, high blood pressure, heart attack, etc] or **injuries** [concussion, etc.]:

List any **surgeries** you have had [cataract, tonsillectomy, appendectomy], and provide date or duration and which eye:

What is your **main problem or chief complaint** regarding your eyes? Please check any of the boxes below that further describes your problem.

	YES	NO	Explanation of Problem
EYES [Glaucoma, cataract, retinal disease, etc.]			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted visions [halos]			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid [blepharitis, stye]			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT [Sinus, ear infection, chronic cough, dry mouth, etc.]			
CARDIOVASCULAR [Heart, vessels, etc.]			
RESPIRATORY [Asthma, emphysema, etc.]			
GASTROINTESTINAL [Stomach ulcers, intestinal disease, etc.]			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS [Arthritis, etc.]			
SKIN [Acne, warts, skin cancer, etc.]			
NEUROLOGICAL [Multiple sclerosis, etc.]			
PSYCHIATRIC [Anxiety, depression, insomnia]			
ENDOCRINE [Diabetes, hypothyroid, etc.]			
BLOOD/LYMPH [Cholesterolemia, anemia, etc.]			
ALLERGIC/IMMUNOLOGIC [Hay fever, lupus, Sjogrens, etc.]			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education [High school, Vocational school, College degree]: _____

Marital Status [Married, Divorced, Single, Widowed]: _____

Living Arrangements: _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? YES NO

If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? YES NO

If YES: occasional 1/2 pack/day 1 pack/day 1+ pack

Are you pregnant? YES NO

Have you ever had a blood transfusion? YES NO

YES NO

History reviewed.

No Changes Additions as noted above

Physicians Signature: _____

Date: _____

Medication List

Patient Name _____ Date _____
(This list must be filled out every six months, expires _____)

Systemic Medications:

Please list all medications, vitamins, supplements that you are currently taking.

Medication	Dosage
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

Eye Medications: Please list all eye medications you are using, including all eye drops.

Eye Medication	Eye - left /right/both	Dose
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Reviewed with Patient (Date/Initials)

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information by asking to speak to our Privacy Officer or for written inquiries note “Attention Privacy Officer”.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
H.I.P.A.A. Privacy Act

RETINA CONSULTANTS OF WESTERN NEW YORK

6637 MAIN STREET
WILLIAMSVILLE, NY 14221

3345 SOUTHWESTERN BLVD
ORCHARD PARK, NY 14127

6933 WILLIAMS ROAD
NIAGARA FALLS, NY 14304

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (H.I.P.A.A.), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient (if other than self): _____

Signature: _____ Date: _____

.....
DESIGNATION OF PERSONAL REPRESENTATIVES:

Persons you give the Practice authorization to speak to on your behalf would be listed below.
If no one is indicated, the patient is the only individual the Practice can speak to other than their medical providers.

I, _____, hereby designate the following as my personal representatives for
(Print name of patient)
purposes of all rights, obligations and responsibilities created under the H.I.P.A.A. privacy rules.

1. _____
(Print name of representative and their phone number)

3. _____
(Print name of representative and their phone number)

2. _____
(Print name of representative and their phone number)

4. _____
(Print name of representative and their phone number)

I acknowledge and agree that Retina Consultants of WNY may disclose my protected health information to my personal representatives and that my personal representatives have the authority to authorize the practice to use and disclose my protected health information.

Signature: _____ Date: _____

CONSENT FOR EXAMINATION and DILATING EYE DROPS

Patient Name: _____ Chart #: _____

Consent for Examination:

I hereby consent to such examination procedures as, in the judgment of my physicians, may be considered necessary or advisable while a patient of Retina Consultants of WNY. I recognize that my treatment and care could be observed and in some instances aided by physicians and/or technicians under supervision.

X _____ Date: _____
Patient (or person authorized to sign for patient)

X _____ Date: _____
Witness



Information regarding Dilating Eye Drops:

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

X _____ Date: _____
Patient (or person authorized to sign for patient)

X _____ Date: _____
Witness

Signature on File / Assignment of Benefits / Financial Statement

Patient Name (print)

Insurance ID#

- MEDICARE:** I request that payment of authorized Medicare benefits are made on my behalf to Retina Consultants of WNY, for services furnished me by Retina Consultants of WNY. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (Formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Retina Consultants of WNY accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
- MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Retina Consultants of WNY, if possible or otherwise to me.
- RELEASE OF INFORMATION:** Retina Consultants of WNY may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation (1) which is or may be liable or under contract to Retina Consultants of WNY for reimbursement for services rendered, and (2) any health care provider for continued patient care. Retina Consultants may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
- OTHER INSURANCE:** I understand that Retina Consultants of WNY maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Retina Consultants of WNY has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Retina Consultants of WNY if I belong to a plan that does not appear on the above mentioned list.
- NON-COVERED SERVICES:** I understand that Retina Consultants of WNY's contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items of services, which are determined by the health care service plans not to be covered. Example of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Retina Consultants of WNY to obtain necessary health care service plan authorizations.
- FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Retina Consultants of WNY, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Retina Consultants of WNY for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Retina Consultants of WNY. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Retina Consultants of WNY. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the bill.

Patient Signature or Authorized Party

Date

RE: PROFESSIONAL COURTESY AND COPAYS

To Our Colleagues and Patients:

Professional Courtesy and the routine waiver of non-collection of deductibles and copayments have been identified by the Office of the Inspector General as a fraud and abuse risk area. To extend those courtesies is to invite scrutiny from the OIG and risk civil monetary penalties and exclusion from federal healthcare programs. To this end, we will no longer extend professional courtesy, no longer be able to waive or decline copayments, accept assignment unless allowed by your insurance company, or write off any charges without evidence of financial hardship. Thank you for your continued support and cooperation.

NO SHOW POLICY

We, at RETINA CONSULTANTS OF WNY, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel or reschedule appointments by calling the following number: (716) 795-2010.

If you do not present to the office for your appointment, this will be documented as a “No Show” appointment and a \$50.00 No Show Fee will be assessed. To avoid this situation, we request you provide us with your cell phone number and/or email address so that we can send you appointment reminders.



PATIENT ETIQUETTE AGREEMENT

Date: _____

We value and provide all patients with high-quality care and service. To do so, we need to set boundaries and expectations that will foster an effective provider-patient relationship.

Below is an agreement that outlines patient responsibilities and appropriate behaviors. In return for your cooperation and active participation in your care, we will make every effort to accommodate you and your needs. Please review the agreement carefully.

In an effort to better care for you, the following expectations are required to maintain an effective provider-patient relationship.

Expectations:

1. I will treat staff with respect and dignity whether in the office or on the phone.
2. I will use a normal tone of speech when speaking with staff.
3. I will use appropriate language when speaking in the office or on the phone with staff.
4. I will adhere to my treatment plan and recommendations.
5. I will comply with the office's policies and procedures.

Signature: _____ Date: _____

I have read and understand the above listed expectations. I also understand that failure to meet these expectations may result in immediate termination of the relationship between me and Retina Consultants of Western New York.