PATIENT INFORMATION

PLEASE PRINT

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____

ADDRESS:_____ **CITY:** _____ **ST:**_____ **ZIP:**_____

PHONE: HOME(____)_____ **OCCUPATION:**_____

WORK(____)_____ **EMPLOYER:** _____

CELL(____)_____ **TEXT: YES / NO**

SOCIAL SECURITY #:_____ **MARITAL STATUS: Mrd Sngl Div Wid**

BIRTHDATE:_____ **AGE:**_____ **SEX: Male / Female**

EMAIL:_____ **DRIVER'S LIC NUMBER:**_____

ARE YOU CURRENTLY LIVING AT A FACILIY: YES / NO IF YES- WHERE:_____
ARE YOU CURRENTLY IN HOSPICE: YES / NO

APPOINTMENT RESTRICTIONS? YES OR NO SPECIFY_____

Language:English/Spanish/other_____

Ethnicity:Hispanic or Latino/ Not Hispanic or Latino

Race:American Indian/Asian/African American/Hispanic/Pacific Islander/White

NAME OF ALTERNATE PERSON TO CONTACT

NAME:_____ **PHONE:(___)**_____

RELATIONSHIP:_____ **ALTERNATE PHONE #:(___)**_____

THE FOLLOWING INFORMATION IS REQUIRED FOR US TO BE ABLE TO FILE WITH YOUR INSURANCE COMPANY:

INSURANCE POLICYHOLDERS NAME:_____

BIRTHDATE:_____ **RELATIONSHIP:**_____

SOCIAL SECURITY #:_____ - ____ - _____

REFERRING DR:_____ **CITY:** _____ **ST:**_____

I authorize any and all insurance benefits to which I am entitled for services rendered by The Retina Center, P.A. to be paid directly to The Retina Center, P.A.. I agree it is my responsibility to pay charges not covered by my insurance. I authorize any holder of medical or other information about me to release to the Social Security Administration, HCFA and its subsidiaries, and other insurance carriers or health care providers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE:_____ **DATE:**_____

Name: _____
DOB: ____/_____/_____ Height:_____ Weight:_____
Referring Provider:_____ Eye Care Provider:_____
Primary Medical Physician:_____
Local Pharmacy:_____
Mail in Pharmacy:_____

Eye History

1. What specific eye problems or visual difficulties are you experiencing now?

_____
_____
_____
_____

2. Have you had any eye surgery, laser treatment to the eye, or eye injury? **Yes** **No**
If yes, please explain:

_____
_____
_____
_____

3. What ***eye*** medications are you using at present? Give name(s) , dosage, and how often taken:

_____
_____
_____
_____
_____
_____

Medical History please circle yes or no

4. Do you have now, or have you had:		If yes, explain date,duration & treatment
Diabetes Mellitus		Yes No
Heart attack		Yes No
Angina or chest pain		Yes No
Irregular or rapid heart beat		Yes No
Heart failure		Yes No
Cardiac pacemaker inserted		Yes No
High blood pressure		Yes No
High cholesterol		Yes No
A stroke or "shock"		Yes No
Anemia		Yes No
Emphysema or bronchitis		Yes No
Asthma		Yes No
Stomach or duodenal ulcer		Yes No
Arthritis	Yes No	If yes, list type

5.Are you allergic to any medication or foods? Yes No

Iodine/Shellfish

If yes, please describe substance, with date of reaction and type reaction: _____

6.Have you ever been diagnosed with cancer?
If yes, please indicate type and date-

_____
_____
_____
_____

Patient Name:_____ DOB:_____

7. What medications or vitamins do you take? Give name(s) and dosage:(if you have a list circle "see list") **See List**

_____

_____

_____

_____

8. What operations (other than eye surgery) have you had?

_____

_____

_____

_____

9. Do you smoke? Yes No Are you a former smoker Yes or No

Dates: _____

10. Occupation: _____

Biological Family History

11. Among blood relatives, is there a history of any of the following:	Please circle yes or no and specify who	
Diabetes Mellitis	Yes No	
Tumor or cancer	Yes No	
High blood pressure	Yes No	
Heart disease	Yes No	
Other medical problems specify you or family	Yes No	Please list & specify:

Review of Systems (current)

Please circle any of the following symptoms that you are **currently** experiencing:

General: Fever, weight loss, weight gain, fatigue, chills
Eye: Blurred vision, fluctuating vision, loss of side vision, double vision, dryness, excess tearing, mattering, redness, itching, burning, glare, light sensitivity, eye pain
Ear, Nose, Throat: Sinus congestion, runny nose, postnasal drip, dry mouth, sore throat, ear ache
Heart: Chest pains, palpitations, increased heart rate, leg edema
Lungs: Shortness of breath, cough, wheezing
Gastrointestinal: Reflux, nausea, vomiting, diarrhea, constipation
Genitourinary: Kidney stones, bladder problems, dialysis, painful or frequent urination
Skin: Rashes, changes to hair, skin or nails
Musculoskeletal: Joint pain, arthritis, muscle weakness, back pain
Neurologic: Dizziness, headache, memory loss, gait disturbances, loss of coordination
Hematologic/Lymphatic: Easy bleeding, easy bruising, swollen lymph nodes, swollen glands
Allergic/Immunologic: Sneezing, itching, food allergies, seasonal allergies, immune disorders
Psychiatric: Anxiety, depression, panic disorders
Endocrine: DM-High/low blood sugar, auto immune disease, adrenal dysfunction, graves disease, thyroid disease, hair loss, excessive perspiration, dry skin, sensitivity to heat or cold

Have you had a flu vaccine for this season? Yes____ NO___
Have you had a pneumonia vaccine? Yes____ NO___

Patient Signature:_____ Date:_____

For Office Use:
Completed by: _____ Date:_____

\\TRCMDO\User\!! TRC New Organization\Clinic Management and Paperwork\Forms\Clinic Forms\Front Office Forms\New Patient Packet Info\Med History and ROS 042817.doc

The Retina Center, P.A.

2806 East 29TH Street
Bryan, TX 77802
(979) 776-8330 Office 800-241-7741 Toll Free (979) 774-9157 Fax

I have received a copy of the "USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION" form

_____ _____

Patient's Signature Date

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as "HIPAA", you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of this form.

Designation Section

I, _____(patient name) hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Print Name of Representative	Relationship to patient	Telephone number
Print Name of Representative	Relationship to patient	Telephone number
Print Name of Representative	Relationship to patient	Telephone number

The authority of this person, when acting as my personal representative, is restricted to the following functions:

"This person is to be afforded all of the privileges that would be afforded to me with respect to my health information."

_____ _____

Patient's Signature Date

KEEP THIS INFORMATION

The Retina Center, P.A.
2806 East 29th Street
Bryan, TX 77802
(979) 776-8330 Office 800-241-7741 Toll Free (979) 774-9157 Fax

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Derek P. Kuhl/ MD, Kevin M. Wells, MD/ Ashley Risner, OD to use or disclose the following protected health information (PHI):

Patient Intake Form	Patient Wavers and Contents	Progress Notes
Diagnostic Reports	Diagnostic Test Order Form	Consultant's Notes
Hospital Admission Reports	Hospital Discharge Notes	Surgeon Operative Reports
Referral and Authorization Forms	Denial Letters	Medication/Drug Record
Prescription Forms	Doctor's First Report of Injury	Patient Correspondence
Requests for Records	Transcribed Notes	Death Certificates
Medical Malpractice Correspondence	Health Plan Correspondence	Patient Surveys
Clinical Research Data	Claims	Payment Remittances/ Advices
EDI Reports	Explanation of Benefits	Enrollment and Eligibility Data
Electronic Medical Records	Electronic Patient Account Ledgers	Collection Agency Forms
Patient Billing Statement		

The protected health information may be disclosed to or viewed by:

Medical Equipment Vendor	Outpatient Treatment Facility	Diagnostic Imaging Facility
Medical Services Contractor	Ambulatory Surgical Center	Ambulance Service Company
Hospital	Medical Billing Contractor	Laboratory
Medical Services Contractors	Clearing for Electronic Billing	Collection Agency
Referring or Consulting Physician	Home Health Agency	Transcription Company
Insurance Company	Pharmacy	

This protected health information is being used or disclosed to conduct patient care.
This authorization shall be in force and in effect without an expiration date unless noted.

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:
The Retina Center, PA
2806 East 29th Street
Bryan, TX 77802
ATTN: Privacy Officer

PRIVACY NOTICE

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.

This Privacy Notice is being provided to you as a requirement of a Federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your Protected Health Information, referred to as "PHI", to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information in some cases. Your "protected health information" means any written and oral health information about you; including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and relates to your past, present, and future physical or mental health condition.

Uses and Disclosures Of Protected Health Information (PHI)
We may use your PHI for purposes of providing treatment, obtaining payment for treatment and conducting health care operations. Your PHI may be used or disclosed only for these purposes unless the physician has obtained your authorization or the HIPPA privacy regulations or state law otherwise permits the use or disclosure. Disclosures of your PHI for the purposes described in this Privacy Notice may be made in writing or by fax.

A. **Treatment**- We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your PHI to a pharmacy to fill a prescription or to a laboratory to order a blood test. In some cases we may also disclose your PHI to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment**- Your PHI will be used, as needed, to obtain payment for the services we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. We may also disclose PHI to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan.

C. **Operations**- We may use or disclose your PHI as necessary, for our own health care operation and to provide quality care to all patients. Health care operations may include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees or practitioners in health care learn under supervision, accreditation, certification, licensing, or review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs and business management and general administrative activities. In certain operations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures**- As part of your treatment, payment and health care operations, we may also disclose your PHI for the following purposes: to remind you of your surgery date, to inform you of potential treatment alternatives or options, or to inform you of health-related benefits or services that may be of interest to you.

Uses and Disclosures Beyond Treatment, Payment and Health Care Operations Permitted Without Authorization or Opportunity to Object
Federal privacy rules allow us to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

A. **When Legally Required**- We will disclose your PHI when we are required to do so by federal, state or local law.

B. **When there are Risks to Public Health**-We may disclose your PHI for the following public activities and purposes:
1. To prevent, control, or report disease, injury or disability as permitted by law.
2. To report vital events such as birth or death as permitted or required by law.
3. To conduct public health surveillance, investigations and interventions as permitted or required by law.
4. To collect or report adverse events and product defects, track FDA regulated products; enable product recalls, repair or replacements to the FDA and to conduct post marketing surveillance.
5. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
6. To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. **To Report Suspected Abuse, Neglect or Domestic Violence**- We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. **To Conduct Health Oversight Activities**- We may disclose your PHI to a health agency for activities including audits, civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your PHI under this authority if you are the subject of an investigation and your PHI is not directly related to your receipt of health care or public benefits.

E. **In Connection with Judicial and Administrative Proceedings**- We may disclose your PHI in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your PHI in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes**- We may disclose your PHI to a law enforcement official for law enforcement purposes as follow:
1. As required by law for reporting of certain types of wounds or other physical injuries.

2. Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process.
3. For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
4. Under certain limited circumstances, when you are the victim of a crime.
5. To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
6. In an emergency to report a crime.

G. **To Coroners, Funeral Directors and for Organ Donation**- We may disclose PHI to a coroner or medical examiner for identification purposes to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. PHI may be used and disclosed for cadaveric organ, eye or tissue donation.

H. **For Research Purposes**- We may use or disclose your PHI for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your PHI.

I. **In the Event of a Serious Threat to Health or Safety**- We may consent with applicable law and ethical standards of conduct, to use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety, or to the health and safety of the public.

J. **For Specified Government Functions**- In certain circumstances, federal regulation authorize the facility to use or disclose your PHI to facilitate specified government functions relating to military and veteran's activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and law enforcement custodial situations.

K. **For Worker's Compensation**- We may release your PHI to comply with worker's compensation laws or similar programs.

Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your PHI to your family members or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition, or death. You may object to these disclosures. If you do not object to these disclosures, or we can infer from the circumstances that you do not object, or we determine in the exercise of our professional judgment that it is in your best interest for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your PHI as described.

Your Rights

You have the following rights regarding your PHI:

A. **The Right to Inspect and Copy your Protected Health Information**- You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain your PHI. A "designated record set" contains medical and billing records and any other records that are used for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law that prohibits access to PHI. In the event that denial has been the decision, review of this denial may be your right. We may deny your request to inspect or copy your PHI if, your safety or that of another person, it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision. To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the copying, mailing or other costs incurred by us to comply with your request. Please contact our Privacy Office if you have questions about access to your medical record.

B. **The Right to Request a Restriction on Uses and Disclosures of Your PHI**- You may ask us not to use or disclose certain parts of your PHI for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. In the event that you are in need of emergent care, we will make attempts to respect your requested restrictions only in the event it does not interfere with your health care. Under certain circumstances, we may terminate your agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The Right to Request to Receive Confidential Communications From Us by Alternative Means or to an Alternative Location** – You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The Right to request Amendment to your PHI**- You may request an amendment of your PHI in a designated record set forth as long as we maintain this information. In this written request you must also provide a reason to support the requested amendments. We may deny your request for an amendment. If we deny your request for an amendment, we will inform you. Request for an amendment must be in writing and must be directed to our Privacy Officer.

E. **The Right to Receive an Accounting**- You have the right to request an accounting of certain disclosures of your PHI made by us. This right applies to disclosures for purposes other than treatment, payment, health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, or disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period not in excess of six years from the date of your request. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Φ. **The Right to Obtain a Paper Copy of this Notice**- Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy of the notice or have agreed to accept this notice electronically.

Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice and to make the new Notice provisions effective for all future PHI that we maintain. If we change the Notice, we will provide a copy of the revised Notice via regular mail or through in-person contact.

Complaints

You have the right to express complaints to us and to the Secretary of the Health and Human Services if you believe that your privacy rights have been violated. You may complain to us by contacting our Privacy Officer in writing using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

Our contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that we have violated your privacy rights you may submit a complaint to our Privacy Officer by sending it to:

The Retina Center, PA
2806 East 29th Street
Bryan, TX 77802
ATTN: Privacy Officer
Phone: (979)776-8330
800-241-7741

This notice is effective April 14, 2003