New York Retina Center
Patient Registration

Name: _____ Today's Date: _____
Last First MI Month/Date/Year

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Age: _____ Date of Birth: _____ Pronouns: _____ Marital Status: S M W D
Month/Date/Year

Email Address: _____

Ethnicity: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or other Pacific Islander [ ] White [ ] Hispanic[ ] Two or more Races (Not Hispanic or Latino)

Employed By: _____ Retired: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse or Parent's Name: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Telephone: _____

Different person responsible for payment? _____ Relationship: _____

Address: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

If you are married, what is the date of birth of your spouse? _____

What is the name of your primary care physician? _____ M.D. D.O.

What is your pharmacy name, address, and zip code? _____

How did you hear about our office? Internet Friend Family Member Hospital Health Plan Directory

Another patient, who? _____ Another doctor, who? _____

Health Insurance Information:

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number**: _____

If not Medicare, what is the name of your primary medical insurance? _____

Non-Medicare primary insurance holder's name: _____
Last First MI

Do you have secondary medical insurance? Yes No Secondary Insurance Name: _____

For billing purposes, our receptionist may wish to make a copy of your insurance plan cards.

Medical History Questionnaire:

(Please print clearly and use the back of this page if you need more space)

Today's date: _____

Name: _____

Your age: _____ Your birthplace: _____

Who is your medical doctor? _____

What is the main reason for your visit today?

_____

_____

Do you have any of these eye symptoms?

[ ] Blurred distance vision
[ ] Blurred reading vision
[ ] Blurred reading vision
[ ] Constant double vision
[ ] Flashing lights or floaters
[ ] Red eyes
[ ] Glare, halos around lights
[ ] Itching or burning eyes
[ ] Eye mattering or tearing
[ ] Foreign body sensation
[ ] Eye pain
[ ] Dry eyes

Have you ever had any of these eye problems?

[ ] Cataract
[ ] Glaucoma
[ ] Macular degeneration
[ ] Dry eyes
[ ] Wore eye patch as a child
[ ] Diabetic Retinopathy
[ ] Other: _____
[ ] Serious eye injury
[ ] Iritis/uveitis
[ ] Lazy eye
[ ] Myopia (Near sighted)
[ ] Retinal detachment
[ ] Hyperopia (Far sighted)

Please list any *eye* surgeries you have had:

[ ] None
[ ] Cataract surgery
[ ] Corneal Transplant
[ ] LASIK
[ ] RK
[ ] PRK
[ ] Foreign body removal
[ ] Vitrectomy
[ ] Retinal laser surgery
[ ] Blepharoplasty surgery
[ ] Trabucelectomy (glaucoma)
[ ] Strabismus surgery (eye muscle)
[ ] Punctal plugs

Which *eye* medications do you currently take?

[ ] None [ ] Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these conditions?

[ ] None [ ] Dizziness [ ] High blood pressure
[ ] Stroke [ ] Allergies [ ] Heart disease
[ ] Arthritis [ ] AIDS, HIV [ ] Lung disease
[ ] Diabetes [ ] Anemia [ ] Thyroid disease
[ ] Cancer [ ] Other: _____
[ ] Headaches _____

If you have glaucoma:

In what year was the diagnosis first made?

_____

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you have any allergies to any medications?

[ ] None known [ ] Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Have members of your family had any eye disease?
(This would be your father, mother, sister, brother, grandparents)

[ ] Glaucoma [ ] Diabetic eye disease or diabetes
[ ] Cataract [ ] Crossed eyes [ ] Macular degeneration
[ ] Iritis/uveitis [ ] Blindness [ ] Retinal detachment
[ ] Poor vision [ ] Other: _____

What non-surgery illness have caused a hospital stay?

_____

_____

_____

Please list any *other* surgeries you have had:

[ ] None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____

Which *other* medications do you currently take?

[ ] None [ ] Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Do you use:

Tobacco [ ] No [ ] Yes How much: _____

Alcohol [ ] No [ ] Yes How much: _____

If yes, how much? _____

What was the approximate date of your last eye examination: _____

Name: _____ **Today's date:** _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Ears, Nose, Mouth & Throat [ ] No problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.

Other: _____

C-V (Heart & Blood Vessels) [ ] No problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking, dizziness, fainting, shortness of breath. Other: _____

Const. (Health in General) [ ] No problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.

Other: _____

Resp. (Lungs & Breathing) [ ] No problems night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, asthma.
Other: _____

GI (Stomach & Intestines) [ ] No problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) [ ] No problems Painful urination, frequent urination, blood in urine, urgency, prostate problems, bladder problems, impotence history of kidney stones. Other: _____

Psychiatric (Mood & Thinking) [ ] No problems Insomnia, irritability, depression, anxiety, mood swings, hallucinations, difficulty sleeping. Other: _____

Endocrinologic (Glands) [ ] No problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) [ ] No problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, heavy aspirin use. Other: _____

MS (Muscles, Bones, Joints) [ ] No problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) [ ] No problems Rash, sores, lesions, eczema, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) [ ] No problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Allergic/Immunologic [ ] No problems Seasonal allergies, hay fever symptoms, hives, itching, frequent infections, exposure to HIV. Other: _____

New York Retina Center
161 E 32nd st
New York, NY 10016

CREDIT POLICY AND FINANCIAL AGREEMENT

- As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment thereof**. If we are contracted with your insurance company we will accept assignment and you will be responsible for your payment portion at the time of service. **Failure to provide necessary referrals and/or authorizations or failure to provide accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party**. You are expected to understand your benefits coverage and responsibilities. This includes, obtaining referrals and/or authorizations, which your insurance company requires **before** care is provided. If we do not have a contractual obligation with your insurance company you are responsible for 100% of the payments at the time services are rendered. If one of our doctors is a participating physician for your primary insurance plan, payment for any deductibles co-pay amounts and non-covered services will be due at the time of service.

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services that you receive in our office. It is simply not possible for the staff of this office to know how each and every insurance plan works.

- A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically *not a covered benefit of your insurance plan*. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.

- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services would be: the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by the supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.

- Payments on all accounts billed is expected within 30 days. If your account is sent to collections a 25% collections fee will be added.

- There is a $50 fee for appointments that are not canceled within at least one (1) day advance notice.

- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

ASSIGNMENT OF BENEFITS:

- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to **New York Retina Center** . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize **New York Retina Center** to release any and all information necessary to payment.

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information, for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signed: _____ Date: _____

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE **New York Retina Center** to examine and treat me, or the individual for whom I am responsible.

During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off.

I authorize **New York Retina Center** to release information acquired in the course of my examination and treatment to my insurance carriers.

I further understand that I have primary responsibility for payment of my charges.

X _____

Signature of Patient (or guardian)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, **New York Retina Center** will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X _____

Signature of Medicare Beneficiary

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. You have the right to obtain a paper copy of this Notice upon request

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billings, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminds. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donating agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public from another person.
Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the right to the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty:

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices:

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints:

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person:

If you have any questions, requests, or complaints, please contact:

Privacy Officer

Brandon B Johnson, MD
New York Retina Center
161 E 32nd st
New York, NY 10016

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:

_____

Date: _____

If not signed reason why acknowledgement was not obtained:

_____
_____
_____

Staff witness seeking acknowledgement:

_____

Date: _____