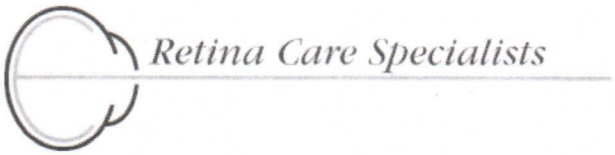


Patient Name_____ **Date of Birth** ___/___/____

CIRCLE ONE: I have/ I have not been previously vaccinated for pneumonia.

CIRCLE ONE: I have/ I have not been previously vaccinated for COVID 19.

CIRCLE ONE: I have / I do not have a living will.

CIRCLE ONE: I have / I do not have a health care proxy. If so, please provide their name & phone number below:

Name: _____ **Phone:** _____

____ I hereby authorize Retina Care Specialists to contact me by telephone and if I am not available, they may leave appointment or medical messages on my answering machine.

____ **DO NOT** leave a message on my answering machine other than the name of the caller and telephone number.

NOTICE OF PRIVACY POLICY-PATIENT ACKNOWLEDGEMENT-HIPAA CONTACT LIST

The following people should be contacted in the event of a medical emergency and are authorized to discuss my medical condition/billing info with the healthcare professionals in this practice.

Name: _____ **Relationship**_____

Phone #: _____

Name: _____ **Relationship**_____

Phone #: _____

I have received and read a copy of the Notice of Privacy Practices of Retina Care Specialists.

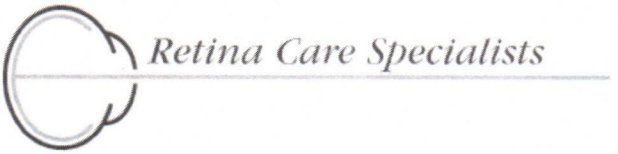
RELEASE OF INFORMATION

I hereby authorize any doctor, hospital, or medical facility to release records to Retina Care Specialists.

I authorize Retina Care Specialists to import/access a current list of my prescribed medications from the Surescripts national database into my electronic medical record. I authorize telehealth/video calls from my provider.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____



Patient's Name_____

Local Address_____

City_____ **State**_____ **Zip Code**_____

Alternate Address

_____

Social Security # _____ **Birth Date**____/____/_____

Birth Sex *(CIRCLE ONE)* Male /Female

Marital Status *(CIRCLE ONE)* Single / Married / Divorced / Widowed

Race *(CIRCLE ONE)* African American / Asian / White / Hispanic/ Other_____

Preferred Method of Contact (CIRCLE ONE) EMAIL / HOME PHONE / CELL PHONE /NONE

Home Phone #_____ **Cell #** _____

Email_____

Employer_____ **Phone #**_____

Emergency Contact_____ **Phone#**_____

Primary Care Physician_____ **Phone #**_____

Referring Physician_____ **Phone #**_____

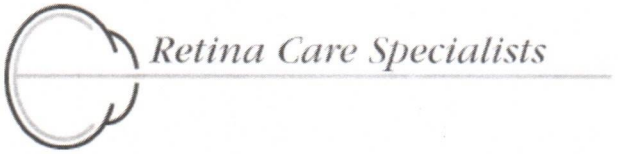
Cardiologist_____ **Phone #**_____

Preferred Pharmacy_____ **Phone #**_____

Insurance Company_____

Policy Holder Name _____**D.O. B**_____

Secondary Insurance_____



Chief Complaint / Reason for Visit:

_____

_____

_____

Duration of Complaint:

_____

Medical History-Current or Past (Please circle all that apply)

Anxiety
Arthritis
Asthma
A-FIB
Cancer (Type: _____)
COPD
Depression
Diabetes
GERD
Other_____

Hearing Loss
Heart Disease
High Blood Pressure
Hyperthyroidism or Hypothyroidism
Kidney Disease
Pulmonary Embolism (PE)
Seizures
Stroke
None

Surgical History (Please circle all that apply)

Appendix
Bladder
Breast
Bypass
Colon
Gallbladder
Other_____

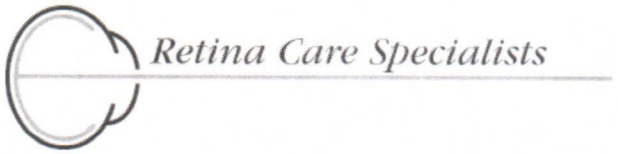
Heart Stents
Joints
Kidney
Liver
Ovaries
Pacemaker

Pancreas
Prostate
Skin
Uterus
None

Ocular History (Please circle all that apply)

Cataract (Right/Left/Both)
Diabetic Eye Disease (Right/Left/Both)
Dry Eye (Right/Left/Both)
Flashes of Light (Right/Left/Both)
Glaucoma (Right/Left/Both)
Macular Degeneration (Right/Left/Both)
Macular Wrinkle/Hole (Right/Left/Both)
None

Narrow Angles (Right/Left/Both)
Ocular Hypertension (Right/Left/Both)
Ocular Migraine
Retinal Tear/Detachment (Right/Left/Both)
Strabismus (Right/Left/Both)
Vitreous Detachment (Right/Left/Both)
Vitreous Floaters (Right/Left/Both)
Other_____



Ocular Surgery (Please circle all that apply)

Cataract Surgery (Right/ Left/ Both)
Corneal Transplant (Right/Left/Both)
Glaucoma Surgery (Right/Left/Both)
Eye Injections (Right/Left/Both)
Eye Muscle Surgery (Right/Left/Both)
Refractive Surgery (Right/Left/Both)
Retinal Tear/Detachment/Laser (Right/Left/Both)
YAG Laser after Cataract Surgery (Right/Left/Both)

Medications (List all current eye, oral & OTC medications & vitamins)

_____

_____

_____

Allergies (List all allergies to medication or food)

_____

_____

Social History (Please circle all that apply)

Smoking Status: Never / Current / Previous (Total Years___ Packs per day_____)

Do you drink alcohol? Yes / No How many drinks per day? _____

Driving Status: Daytime / Night / No longer driving

Where do you live? Private Home / Assisted Living / Rehab or Skilled Nursing Facility

Do you live alone? Yes / No

Who do you live with: _____

Occupation: _____ Currently Working / Retired

Hobbies: _____

Family History (Please circle all that apply & state family member history applies to)

Blindness_____
Cancer_____
Diabetes_____
Glaucoma_____
Heart Disease_____
Hypertension_____
Macular Degeneration_____
Retinal Detachment_____
Stroke_____

PATIENT DILATION CONSENT FORM

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 your 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, its best if you plan not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctors of Retina Care Specialists and/or assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date of birth

_____ _____

Witness Date

FINANCIAL POLICY AGREEMENT

Thank you for choosing Retina Care Specialists to treat your retinal condition. We are committed to excellent patient care. Below we have provided an explanation of our Financial Policy Agreement.

Please initial each:

_____1. Each patient is responsible for his or her own bill. Insurance co-payments, co-insurances and deductibles are to be paid in full at each visit and prior to any surgery. Your insurance policy is a contract between you and your insurance company. We accept cash, check & major credit cards.

_____ 2. As a courtesy, Retina Care Specialists will file claims to your insurance company. You **must** provide all insurance policy information and changes to our office. If the insurance company has changed and you have failed to inform us, you will be responsible for payment of the visit. Your bill is your responsibility.

_____ 3. "Self-pay" patients (and patients with limited health insurance) are required to pay 100% of services rendered at each visit. A minimum of $500 is expected on the initial visit. For extended treatments, payment plans are available and can be made with the Billing Office prior to any medical evaluation, procedure, or treatment.

_____ 4. Bills unpaid for more than 60 days will be turned over to a collection agency. Additional fees may be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____ 5. As a specialty group, some insurance companies require that an authorization or referral be obtained prior to your visit. It is your responsibility to know if your insurance requires this and to obtain the referral/authorization. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

_____6. A $35.00 fee will be charged on all returned checks.

_____7. From time to time, you may ask us to complete various forms (such as disability forms), there is a $25 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company. Please allow 7-14 business days.

_____8. We may charge up to $25 for the reproduction of your medical records based on guidelines from the State of Florida and the Federal Government.

_____9. I understand that failure to maintain routine eye visits or excessive cancellations and no-shows may result in detrimental eye complications and/or dismissal from the care of Retina Care Specialists.

_____10. **AUTHORIZATION TO PAY BENEFITS:** I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to Retina Care Specialists, for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____	_____	_____
Signature of patient or responsible party	RCS Witness	Date