Patient Information
Revised May 9, 2014

Date _____ Physician _____

Last Name _____ First Name _____ Middle Initial_____

SSN# _____ ☐ M ☐ F DOB_____ Age_____

Address _____ City _____State_____ Zip_____

Home Phone _____ Work Phone _____ Mobile Phone _____

Primary number I wish to have used to contact ☐ Home ☐ Mobile ☐ Work

Email _____ Occupation _____

Marital Status: S M D W Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other

Spouse Name _____ DOB _____ Occupation _____

Mobile Phone _____ Work Phone _____

Need Interpreter? ☐ Yes ☐ No Primary Language: _____

Emergency Contact _____ Relationship _____ Phone _____

Preferred Pharmacy Name _____ Address _____

Primary Insurance _____ ID # _____ Grp # _____

Secondary Insurance _____ ID # _____ Grp # _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

We must have a photo ID on all Patients at every visit.

All information given is accurate. I give permission for this practice to contact me regarding practice information by the above methods.

Print Name _____ Signature _____ Date _____

HIPAA

Please list first and last names of family members or friends that we may discuss your account, visits, or any information regarding your condition or course of treatments.

_____

Advanced Patient Notice

I understand that my physician owns Augusta Retina-Laser SurgiCare, an Ambulatory Surgery Center. He also has partial ownership with Trinity Hospital of Augusta, GA. I understand that I am free to choose another facility in which to receive the services that may be ordered by my physician. I also agree to adhere to the treatment plans recommended by my doctor, and to treat all staff members with respect.

My physician has determined that some procedures can be performed at Augusta Retina. I understand that if an emergency medical condition should occur while being treated at this facility, I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the ambulatory surgical and treatment facility will still transfer me to the closest hospital.

Assignment and Release

I understand, I (or my dependent) have insurance coverage and assign directly to Southeast Retina, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. **I authorize the use of this signature on all Insurance submissions**. If I choose not to file insurance, I understand I am responsible for paying the full non-discounted fee for the services performed.

● Patient or Responsible Party Signature: _____ Date: _____

We do file insurance claims for participating plans. **PLEASE BRING YOUR INSURANCE CARD WITH YOU FOR EVERY APPOINTMENT. WE WILL NOT FILE CLAIMS TO YOUR INSURANCE CARRIER WITHOUT HAVING A COPY OF YOUR CARD.**

All co-payments and deductibles are due at the time of service. $5 Charge if we have to bill your copay. We require a 24 hour notice if you are unable to keep your appointment. A $25 No Show Fee for office, $75 for a Procedure and $150 for surgery will be billed to your account (not covered by insurance – you will be responsible). Effective October 1, 2013.

● **I acknowledge that it is my responsibility for the fees listed above and that copays and deductibles are due at the time of services.**

Patient or Responsible Party Signature: _____ Date: _____

A Signature of Financial Agreement

● **I understand that should my account be placed in an outside collections agency, I agree to the terms that I may be charged all reasonable collection fees.**

Patient or Responsible Party Signature: _____Date: _____

● **We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information that is noted on page 6 and was given to you at the time of your first visit. I hereby authorize Southeast Retina Center, P.C. to give my information concerning my illness and treatment to the physician who referred me or to my insurance company. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 706-650-0061.**

Signature below is only acknowledgement that you have received the Notice of our Privacy Practice revision on September 23, 2013:

Print Name: _____Signature:_____Date:_____

Patient Name _____ Date of Birth _____ Date _____

Medications:

1. _____ 2. _____ 3 _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Allergies:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list family/personal physician with address and phone number:

_____
_____
_____

Patient History:	**Have you ever had:**	**What year were you diagnosed**:
Diabetes:	No Yes	_____
Hypertension:	No Yes	_____
Heart Disease:	No Yes	_____
Lung Disease:	No Yes	_____
Cataracts:	No Yes	_____
Glaucoma:	No Yes	_____

Family History:	**Has a relative had:**	**If so, whom**:
Diabetes:	No Yes	_____
Hypertension:	No Yes	_____
Heart Disease:	No Yes	_____
Lung Disease:	No Yes	_____
Cataracts:	No Yes	_____
Retinal Problems	No Yes	_____
Other:		_____

Please list any surgery you have had:

_____
_____
_____

Patient Name _____ Date of Birth _____ Date _____

Please circle No or Yes. If yes, please write the year diagnosed.

Constitutional Symptoms:

Good general health lately No Yes _____
Recent weight change No Yes _____
Fever No Yes _____
Fatigue No Yes _____
Headaches No Yes _____

Ears/Nose/ Throat/Mouth:

Hearing loss/ringing No Yes _____
Earaches or drainage No Yes _____
Chronic sinus problems No Yes _____
Nose/Mouth bleeding No Yes _____
Mouth sores No Yes _____

Breathing:

Chronic/Frequent coughs No Yes _____
Spitting up blood No Yes _____
Shortness of breath No Yes _____
Asthma or Wheezing No Yes _____

Bowel:

Loss of appetite No Yes _____
Change in bowel movement No Yes _____
Nausea or Vomiting No Yes _____
Frequent diarrhea No Yes _____
Abdominal pain No Yes _____

Urinary:

Frequent urination No Yes _____
Blood in urine No Yes _____
Kidney Stone No Yes _____
Burning/painful urination No Yes _____

Musculoskeletal:

Joint stiffness/pain No Yes _____
Muscle pain/cramps No Yes _____
Back pain No Yes _____
Weak muscles/joints No Yes _____

Skin:

Rash or itching No Yes _____
Change in skin color No Yes _____
Breast pain/lump No Yes _____
Change in hair/nails No Yes _____

Neurological:

Frequent headaches No Yes _____
Lightheaded/dizzy No Yes_____
Convulsions/seizure No Yes_____
Stroke No Yes _____
Head injury No Yes_____

Psychiatric:

Memory loss No Yes_____
Depression No Yes_____
Insomnia No Yes_____
Nervousness No Yes_____

Glands:

Hormone/gland problems No Yes_____
Thyroid disease No Yes_____
Excessive thirst No Yes_____
Dry skin No Yes_____

Blood:

Slow healing after cut No Yes_____
Anemia No Yes_____
Phlebitis No Yes_____
Past transfusion No Yes_____

Allergies:

Penicillin or other antibiotics No Yes Name_____
Morphine or other narcotics No Yes Name_____
Aspirin or other pain remedies No Yes Name_____
Novocain or other anesthetics No Yes Name_____
Other drugs No Yes Name_____

Technician_____ Physician_____

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for this purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclose of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of health and human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before May 9, 2014.

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 PER HIPAA GUIDELINES EFFECTIVE SEPTEMBER *23, 2013*.

This Notice of Privacy Practices describes how we may use and disclose your protected health information(PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health conditions and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice, and any other use required by law.

Treatment: We will use and disclose your protected health information 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 example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The following include Public health issues as required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directions and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation and Inmates. Under the law, we must make disclosures to you when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other permitted and required use and disclosure will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.