RETINA HEALTH CENTER

PATIENT INFORMATION

Name (Last, First, Middle): _____

❑ Male ❑ Female Date of Birth: _____ SS #: _____ Marital Status: _____

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

Home Phone: _____ Secondary Phone #: _____ Email: _____

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

Appointment Reminders: ❑ Phone __Home __Secondary ❑ Email ❑ Text _____

RESPONSIBLE PARTY INFORMATION (If different than above)

Name (Last, First, Middle): _____

❑ Male ❑ Female Date of Birth: _____ SS #: _____

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

PRIMARY INSURANCE

Name of Insurance Company: _____ Policy #: _____

Name of Insured: _____ Group #: _____

(If Spouse) SS #: _____ Date of Birth: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Effective Date: _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Policy #: _____

Name of Insured: _____ Group #: _____

(If Spouse) SS #: _____ Date of Birth: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Effective Date: _____

INSURANCE INFORMATION

Are you or your spouse employed full time or part time? ❑ Yes ❑ No

If so, do you have health insurance through your employer? ❑ Yes ❑ No

Are you enrolled in a HMO? ❑ Yes ❑ No

Do you need authorization from your Primary Care Physician before you can see a specialist? ❑ Yes ❑ No

SKILLED NURSING

Are you or have you been in a skilled nursing facility and/or hospice care in the past 6 months? ❑ Yes ❑ No

If "Yes" - Name of the Facility _____

PHYSICIANS

Primary Care Physician Name: _____ Phone #: _____

Address: _____

General Eye Doctor Name: _____ Phone #: _____

Address: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #: _____

HOW DID YOU HEAR ABOUT US?

❑ Health Fair ❑ Insurance Plan ❑ Newsletter ❑ Newspaper

❑ Patient Referral _____ (Name) ❑ Symposium ❑ Website

❑ Referring Physician _____ (Name) ❑ Yellow Pages ❑ Other

PATIENT CONSENT

I consent to the sending of reports of my evaluation, treatments, and any follow-up evaluations to my referring doctor, the doctor requesting consultation, my family physician, and/or any other health care providers, hospitals, or outpatient facilities that I have identified or will identify to you.

I consent to any holder of personal health information to release to the Social Security Administration and centers for Medicaid and Medicare services or its intermediaries or carriers, or to the billing agents of my insurance companies indicated above or to my employer if this is a worker's compensation claim, any personal health information or other information, including services rendered and obtained reimbursement. I request that payment of Medicare benefits and/or medical insurance benefits be made to myself or to the party who accepts assignment.

I understand that I am fully and legally responsible for payment of the account, which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay the outstanding balance, I also agree to pay all billing charges, collection agency fees, attorney fees and court cost, if applicable.

For Minors (If Applicable):
I give permission for my minor child, _____, to be treated by ALEXANDER M. EATON, M.D./HUSSEIN WAFAPOOR, M.D.

_____ _____

Patient or Guardian Signature Date

PAYMENT POLICY

Please read over the following information very carefully before seeing the doctor. This is to eliminate any confusion regarding office policies. Thank you!

MEDICARE: Our office accepts Medicare assignment. Medicare assignment means we will be reducing our fees to the Medicare allowed amount. Medicare will pay 80% of the allowed amount, hence leaving the 20% copayment as your responsibility. Medicare has a calendar year deductible that must be met before they will pay their 80%. Therefore, if you have not met your Medicare deductible, you will be required to pay it at the time services are rendered.

As a courtesy, our office will file to most supplemental insurance companies. However, if payment is not received within 60 days, you will be responsible for the 20% copayment.

MANAGED CARE PLANS (HMO OR PPO): You are responsible for paying your copayment at the time of your visit. HMO plans are required to have an authorization number or referral slip from the primary care physician. If this is not obtained **prior** to your visit, you will be responsible for full payment at the time services are rendered.

PRIVATE/GROUP INSURANCE: Unless our office has contracted with your private/group health insurance, we do not file the claim for reimbursement. Payment will be due at the time services are rendered.

We accept the following methods of payment: Cash, Check, Visa, MasterCard, Discover, and American Express.

I have read the above office policy completely. I understand and accept this policy.

_____ _____

Patient's Signature Date

FURTHERMORE, I understand that I am entering into a contractual relationship with Retina Health Center, PL d/b/a Retina Health Center and its employees for professional care. **FURTHERMORE**, I understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. **IN FURTHER CONSIDERATION** of professional care provided to me by Retina Health Center, PL d/b/a Retina Health Center and its employees, I and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claims of medical malpractice against Retina Health Center, PL d/b/a Retina Health Center.

FURTHERMORE, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board certified expert medical witnesses in the same or similar specialty as Alexander M. Eaton, M.D. and Hussein Wafapoor, M.D. **FURTHERMORE**, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty societies for expert witnesses in the areas of medicine that would typically have the background and experience to opine on such a case. **IN FURTHER CONSIDERATION** of this, Retina Health Center, PL d/b/a Retina Health Center and its employees agree to the same stipulations.

_____ _____

Patient's Signature Physician's Signature

RETINA HEALTH CENTER

Consent for Purpose of Treatment, Payment, or Health Care Operations

I consent to the use of disclosure of my protected health information by the Retina Health Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations.

I understand that diagnosis or treatment of me by the Retina Health Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Retina Health Center is not required to agree to the restrictions that I may request. However, if the Retina Health Center agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Retina Health Center has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Retina Health Center's **Notice of Privacy Practices** prior to signing this document.

The Retina Health Center's **Notice of Privacy Practices** has been provided to me.

The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations.

A summary of the **Notice of Privacy Practices** for the Retina Health Center is also posted in the waiting room.

This **Notice of Privacy Practices** also describes my rights and duties of the Retina Health Center with respect to my protected health information.

The Retina Health Center reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.**

I may obtain a revised **Notice of Privacy Practices** by contacting the Privacy Officer at the main office of the Retina Health Center located at 1567 Hayley Lane, Fort Myers, Florida 33907 (239) 337-3337.

_____

Name of Patient (Please Print)

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Name of Patient or Representative **Employee Initial**

PLEASE READ CAREFULLY
PATIENT-DOCTOR ARBITRATION AGREEMENT

Chart #:_____

This Agreement is made between ***Retina Health Center, P.L.***, a Florida professional limited liability company, Alexander M. Eaton, M.D., Hussein Wafapoor, M.D. and their employees, agents, and servants (hereinafter collectively referred to as "Doctor") and _____ (hereinafter referred to as "Patient"). It is the intention of the parties to this Agreement to bind not only themselves but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the Doctor listed above for surgical ophthalmology, for ambulatory medical facilities or for other ophthalmology or medical services of facilities ("Services"). The Patient also understands that there are numerous other physicians and facilities in this area who are qualified to render quality Services and the Doctor is willing to refer the Patient to another physician or facility in the area for those Services if the Patient requests. Both the Doctor and the Patient agree that arbitration is a preferable method to resolving any disputes they may have in connection with the Services, and wish to avoid the expense and inconvenience of litigation, whether by judge alone or by jury.

It is mutually agreed that any controversy, dispute or claim arising out of or relating to the Services of any kind, including the medical care rendered or payment of medical or surgical fees, or any other matter whatsoever, including the interpretation hereof, shall be settled by arbitration in accordance with the Florida Arbitration Code. The controversy or claim shall be submitted to a single arbitrator (who must be a physician, licensed in Florida) mutually agreed upon by the parties within thirty (30) days of notice of an intent to arbitrate any matter hereunder. If the parties cannot agree upon an arbitrator within such thirty (30) day period a physician, licensed in Florida shall be selected to serve as the arbitrator in accordance with the Florida Arbitration Code through a court, which has a situs in Lee County, Florida. The arbitration of such dispute will be held in Lee County, Florida within thirty (30) days after completion of discovery. The award of the arbitrator will be final and binding on all parties to the arbitration and judgment may be entered upon it in accordance with law in any court of competent jurisdiction. In the event of arbitration the parties hereto specifically agree that discovery shall be allowed in the form of written interrogatories, depositions of witnesses, production, inspection and copying of documents to the same extent as is provided under the Florida Rules of Civil Procedure. Provided, however, the time for responding to requests for written interrogatories, production and inspection and copying of documents shall be reduced to ten (10) days. Any disagreements between the parties to the dispute as to the scope and extent of and compliance with the discovery will be referred to the arbitrator and his or her determination shall be final. The parties further agree that such discovery procedures shall not be extended beyond two (2) months from the selection of the arbitrator; provided, however, that for good cause, the arbitrator shall be permitted in his or her discretion to extend said time for discovery. All expenses of the arbitrator and arbitration (exclusive of each party's attorneys fees, if any) shall be borne equally between the Patient and the Doctor. The parties hereto agree that should any non-economic damages be awarded, in no event shall the amount of the non-economic damages awarded exceed the limits set forth in Florida Statutes (2011) sec. 766.118 as applicable to the Doctor and the nature of the Services (generally $500,000.00 for non-emergency care [$300,000 for Medicaid patients], with greater amounts allowed under limited exceptions). The definition of non-economic damages and the calculation thereof shall be consistent with the use of said term and the calculation of non-economic damages under Florida Statutes (2011) secs. 766.202(8) and 766.118. Provided, further, the parties hereto agree that no punitive damages may be awarded. Should any part of the provision of this Agreement be held unenforceable or in conflict with law, the validity of the remaining parts or provisions shall not be affected by such holding.

This Agreement shall remain in effect for all treatment, services and surgery provided to the patient presently and at any future date. I (we) have set our hand(s) this _____ day of _____, 20_____.
(Month) (Year)

DOCTOR:

By: _____
Authorized Agent

PATIENT:

By:_____
Patient *(Guardian if patient is a minor)*

By:_____
Patient's Spouse *(If available)*

PATIENT MEDICAL
HISTORY QUESTIONNAIRE

Name:_____ **Acct #:**_____

Date of Birth: _____ **Sex:** ❑ **M** ❑ **F** **Weight:** _____ **Height:**_____ **Race:**_____

Review of Systems:

Please circle any of the following health problems which you have or have had, in the event that nothing is circled, it will be taken as a no.

Cardiovascular

Y N Heart Disease
Y N Heart Attack (Date)_____
Y N Angina
Y N Stroke (Date)_____
Y N High Blood Pressure

Endocrine

Y N Diabetes (Years)_____
Y N Thyroid Disease

Skin and/or Breast Problems

Y N Keloids/Scarring
Y N Breast Cancer

Constitutional

Y N Weakness

Ear/Nose/Throat

Y N Hearing Loss

Respiratory

Y N Lung Disease
Y N Tuberculosis
Y N Chest

Musculoskeletal

Y N Arthritis

Gastrointestinal

Y N Ulcer
Y N Colitis/Diverticulitis
Y N Liver/Hepatitis

Constitutional

Y N Weight Loss: _____

Genitourinary

Y N Kidney
Y N Bladder
Y N Prostate

Hematologic/Lymphatic

Y N Anemia
Y N Bleeding/Bruising

Neurologic/Psychiatric

Y N Seizures/Convulsion
Y N Alzheimer's
Y N Depression
Y N Other: _____

Past Medical History

Please list any major illnesses, injuries, prior operations, hospitalizations other than eye surgery/injury

_____

_____

_____

_____

_____

Please list all <u>medications</u> that you are currently taking, including eye drops and vitamins.

Medication	Strength	How Often	Medication	Strength	How Often

Are you <u>ALLERGIC</u> to any medications? ❑ Yes ❑ No. *If yes, please list:*

_____

_____

Eye History **-** *Please circle the items which you have been diagnosed with.*

Y	N	Cataracts	Y	N	Macular Degeneration
Y	N	Diabetic Retinopathy	Y	N	Retinal Disorders
Y	N	Glaucoma	Y	N	Retinal Detachment

Eye Surgery/Eye Trauma **-** *Please list:*

Right Eye _____

Left Eye _____

Social History *- Please circle yes or no.*

Y	N	Smoking	Y	N	Alcohol	Y	N	Live alone

Occupation/Hobbies _____

Family History *- Please circle yes or no.*

Y	N	Cancer	Y	N	Diabetes	Y	N	Glaucoma
Y	N	Heart Disease	Y	N	Macular Degeneration	Y	N	Retinal Detachment

Other problems, please list:_____

_____

_____

Patient's Signature: _____Date: _____

Updates

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Reviewed by _____/_____ Date_____ ( ) Updated ( ) No change

Name: _____ Acct #: _____

Are you bothered by any of the following (with your glasses or contacts on, if applicable):

_____Blurred Vision

_____ Overall Decline in Vision

_____ Glare, Sensitivity to Light

_____ Poor Night Vision

_____ Seeing Rings Around Lights

_____ Unbalanced Vision

_____ Loss of Depth Perception

_____ Double Vision in One or Both Eyes

_____ Floaters

_____ Halos

Do you have difficulty when you:

_____Drive during daylight hours and/or evening hours?

_____ Read traffic signs and/or try to judge distances?

_____ Read labels, price tags or small numbers?

_____ Do fine handwork or hobbies such as golf, bingo, computer work, or play cards?

_____ Shop for groceries?

_____ Walk, stoop or change positions?

_____ Use stairs?

_____ Other

Patient's Signature: _____ Date:_____

Reviewed By: _____/_____ Date:_____

PATIENT COMMUNICATION FORM

A. **Family and Friends**. It is the office policy of Retina Health Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/ legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any or your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add name later on, please confirm this in writing, or call or staff.)

Spouse: _____	_____ Yes	_____ No
Parent: _____	_____ Yes	_____ No
Other: _____	_____ Yes	_____ No
_____	_____ Yes	_____ No
_____	_____ Yes	_____ No

B. **Alternative Communications**. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:_____
_____
_____

PRINTED NAME: _____

Patient/Parent/Guardian Signature:_____

Date: _____

.....

FOR OFFICE USE
Changes to above authorized by patient over phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice follows this summary.

Date of Last Revision: 12/09/2013
Effective Date: Immediately

This information is made available upon request by a patient.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For Medical Treatment
- To Obtain Payment For Our Services
- In Emergency Situations
- For Appointment and Patient Recall Reminders
- To Run Our Practice More Efficiently and Ensure All Our Patients Receive Quality Care
- For Research
- To Avert a Serious Threat to Health or Safety
- For Organ and Tissue Donation
- For Workers' Compensation Programs
- In Response to Certain Requests Arising Out of Lawsuits or Other Disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice of with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The Right to Inspect and Copy
- The Right to Amend
- The Right to an Accounting of Disclosures
- The Right to Request Restrictions
- The Right to a Paper Copy of This Notice
- The Right to Request Confidential Communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summery