Retina Health Center

1567 Hayley Lane, Suite 101 • Fort Myers, Florida 33907
(239) 337-3337 • Fax (239) 274-6610

2210 Vanderbilt Beach Road, Suite 1100 • Naples, Florida 34109
(239) 793-5200 • Fax (239) 514-7521

Welcome,

You have been scheduled for an appointment with and at our location:

□ Alexander M. Eaton
□ Veronica Graversen
□ Hussein Wafapoor

□ Fort Myers
□ Naples

_____ at _____ am / pm.

Enclosed you will find our registration, history, and visual function forms for you to complete and bring with you to your appointment. In addition, there are maps with directions to our Fort Myers and Naples locations.

Retinal exams tend to be more involved than those for glasses or other problems such as cataracts or glaucoma. As part of the exam, your eyes will be dilated; pictures or a fluorescein angiogram and other tests may be needed based on the doctor's examination of your eyes. As a result, your visit can take as long as three hours. We recommend that you have a driver available following your visit due to the dilation.

Although we accept most insurance such as Medicare and most secondary insurance carriers, we do not accept all HMO's. If you have an HMO, please contact your primary care physician to obtain an authorization for your visit.

Please bring your insurance cards, a photo ID, a list of your medications and the name and phone number of the pharmacy that you use to get your prescriptions filled.

We look forward to seeing you at your scheduled appointment. If you have any questions, please do not hesitate to contact our office at (239) 337-3337.

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RETINA HEALTH CENTER, P.L. ("RETINA HEALTH CENTER") NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY:

Retina Health Center is required to comply with all applicable federal and state laws to maintain the privacy of your Protected Health Information ('PHI'). PHI is defined as "any individually identifiable health information that relates to any physical or mental health or that can otherwise be used to identify the individual".

Retina Health Center is also required to provide you with this notice about our privacy practices, our legal obligations, and your rights concerning your PHI. This notice is effective September 23, 2013 and is subject to any amendments enacted by the governing statutes. Periodic amendments may also be made in order to clarify certain language of the applicable laws and statutes. Due to the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvest Act (ARRA) of 2009, the HIPAA Privacy Rules have evolved and took final form with the release of the Omnibus Privacy Final Rules issued in January of 2013.

You may request a copy of this notice (or any subsequent revision of this notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information:

Retina Health Center may use and disclose your PHI to (1) facilitate your medical treatment, (2) obtain payment from your health insurance company for medical services, and (3) industry standard health care operations. Such use and disclosure of your PHI is considered under HIPAA as **"permissible use"**. Any and all "permissible use" of your PHI will be made within "**minimum necessary**" limitations, and only to facilitate specific activity directly relative to treatment, payment and / or operations.

Following are examples of permissible use of your PHI.

Treatment: Retina Health Center may use and disclose your PHI to provide, coordinate, or manage your health care and any related services as recommended by your medical provider. This includes the coordination or management of your health care with a third party or other physicians who may currently be involved with your medical care or whom it may be determined by your medical condition to be required with your medical care for the purposes of diagnosis and treatment (i.e. specialist, laboratory, hospital, or other facility).

Payment: Retina Health Center may use and disclose your PHI to obtain payment for your health care services. This may include providing copies of the pertinent medical record to your health insurance plan in order to determine eligibility and benefits, obtain pre-authorization on your behalf for recommended medical services, review of medical services provided to you to confirm medical necessity, and other health plan utilization review activities. For example, obtaining approval for a hospital admission may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: Retina Health Center may use and disclose your PHI in order to facilitate industry standard business and operational activities. These activities include, but are not limited to, daily clinic operations relative to scheduling, appointment reminders, assembly and maintenance of your medical record, and inter-departmental coordination of your medical care. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name, call you by name in the waiting room when your doctor is ready to see you, or contact you by telephone or mail to ensure necessary continuum of care or other related activities.

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Retina Health Center may share your PHI with third party "**business associates**" that perform certain activities (i.e. billing, transcription services) for the company. Whenever an arrangement between our office and a business associates involves "permissible use" of your PHI, your PHI is protected by a **Business Associate Agreement** that contains terms that will protect your PHI.

Uses and Disclosures Based On Your Written Authorization: Any other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. Your written authorization may be revoked in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Health information that has been properly de-identified is not protected by the HIPAA Privacy Rule and may be used for research and other statistical purposes.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify as an emergency contact, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Marketing: We may use your PHI to contact you with information about treatment alternatives that may be of benefit or interest to you. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Uses and Disclosures Required by Law:

Research; Death; Organ Donation: Your (de-identified) PHI may be used or disclosed for research purposes in limited circumstances. Your PHI may be disclosed to a coroner, protected health examiner, funeral director, or organ procurement organization under specific circumstances.

Public Health and Safety: Your PHI may be disclosed to the extent necessary to avert a serious and imminent threat to your personal health or safety, or the public health or safety of others. Your PHI may be disclosed to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: Your PHI may be disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: Your PHI may be disclosed to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: Your PHI may be disclosed to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track

products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable state and federal laws, your PHI may be disclosed, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: Your PHI may be disclosed when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by Workers' Compensation or other similar laws.

Process and Proceedings: Your PHI may be disclosed to legally authorized law enforcement officials in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Retina Health Center may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody.

Access: You have the right to review or obtain copies of your PHI, with limited exceptions. You must make a request in writing to the primary practice location where you have most recently received medical services. You may also request access by sending us a letter to the address at the end of this notice. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

Accounting for Disclosures: You have the right to receive a list of instances in which we or our business associates used or disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on the use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make on such a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it (1) is reasonable, (2) specifies the alternative means or locations, and (3) continues to permit Retina Health Center to bill and collect payment for medical services rendered to you in good faith.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. If we comply with your request, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

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Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Website Privacy: Any personal information you provide us with via our website, including your e-mail address, will never be sold or shared with any third party without your express permission. If you provide us with any personal contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other websites. We cannot take responsibility for the policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. **Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.**

Questions and Complaints:

If you want more information about our privacy practices or if you have questions or concerns, please contact Retina Health Center's HIPAA Privacy Officer indicated below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, please submit your concerns in writing to the Retina Health Center HIPAA Privacy Officer indicated below. You also may submit your concerns to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

HIPAA Privacy Officer:

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Office: 1567 Hayley Lane, Fort Myers, Florida 33907

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RETINA HEALTH CENTER, PL (RHC)
PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

Patient Name: _____ Patient Medical Record #: _____

Consent to Use and Disclose PHI & Acknowledgement of Receipt of Notice of Privacy Practices:
General consent to use and disclose personal health information to carry out treatment, payment for treatment and health care operations.

With my signature below, I give RHC permission to disclose my personal health information as necessary to carry out treatment, obtain payment for treatment provided to me and to carry out its health care operations.

A complete description of how RHC will use and disclose my personal health care information can be found in its Notice of Privacy Practices which has been made available to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices may be revised at any time by RHC and that I may view changes to the Notice of Privacy Practices at their website at www.RetinaHealthCenter.com or by requesting a printed copy of revision from the Compliance department in writing. I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the RHC Notice of Privacy Practices.

I have the right to request restrictions regarding how my personal health information is used or disclosed in the course of carrying out treatment, obtaining payment for treatment provided to me and carrying out health care operations. I may request restrictions by filling out the appropriate form which will be provided to me upon request. RHC is under no obligation to implement any of the restrictions that I may request but will be bound by any restrictions that it agrees to implement.

I understand that I may revoke this consent at any time notifying RHC in writing, except to the extent that action has been take in reliance on it.

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Authorization to Release Protected Health Information (PHI):

I hereby authorize RHC to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

Name of Authorized Person	Relationship	Daytime Phone Number

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Documentation of Good Faith Efforts (To be completed if patient unable or unwilling to sign above):

On this day, patient presented for treatment and was provided a copy of the RHC's Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

_____ Patient / Legal Representative refused
_____ Patient / Legal Representative unable due to medical disability
_____ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

Printed Name of RHC Employee: _____

Signature of RHC Employee: _____ **Date:** _____

Internal Use Only

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FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Retina Health Center, P.L. (RHC) are privately-owned medical facilities that provide medical services on a fee-for-service basis. RHC relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. RHC receives no federal, state or other third-party funding; as such, RHC does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

For the convenience of our patients, RHC participates with most medical insurance companies and vision plans. RHC will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc. If we do not participate with your medical or vision insurance(s), we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for pre-payment. A RHC statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

Please note that RHC medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom RHC will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) RHC and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e., cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.), RHC accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

RHC does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

RHC is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, RHC accepts cash, check, money order and credit cards. In addition, RHC offers financing options through third party vendors.

I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Retina Health Cener, P.L. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.

I hereby assign all medical / surgical benefits to Retina Health Center, P.L., for services rendered to me by the medical providers contracted under Retina Health Center, P.L. and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by Medicare and / or my other health insurance company to determine my benefits and issue payment to assignee for related medical claims.

My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.

Patient Name Printed	**Patient / POA Signature**	**Date**

Failure to honor your financial obligations to RHC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

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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., Veronica Graversen, 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 attorney's 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 _____ (Date) day of _____ (Month) ,20 _____ (Year) .

DOCTOR:

By: _____
Authorized Agent

PATIENT:

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

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

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INFORMATION REGARDING DILATING EYE DROPS

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, it's best that you make arrangements 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 Dr. Eaton, Dr. Graversen, and / or Dr. Wafapoor, or their assistants as may be designated by either of them, to administer dilating eye drops today and on future follow up exams. I understand that the eye drops are necessary to diagnose, follow, and / or manage my condition.

Patient Name Printed	**Patient / POA Signature**	**Date**
Patient Chart #	**Witness Signature**	**Date**

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PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: Mr. Mrs. Ms. Dr. _____

Date of Birth: _____ **SSN:** _____ ☐ Male ☐ Female

Address: _____

Home Number: _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** _____

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Language: ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: _____

Florida Resident: ☐ Full Time ☐ Part Time If Part Time, please complete information below.

From: _____ To: _____ Secondary Home Phone: _____

Secondary Address: _____

Northern Physician: _____ Phone: _____ Fax: _____

Responsible Party Information (If different from above):

Name: _____ Date of Birth: _____

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

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 an HMO? ☐ Yes ☐ No

Do you need authorization from your Primary Physician to see a specialist? ☐ Yes ☐ No

Have you been in a skilled nursing a facility and/or hospice care in the past 6 months? ☐ Yes ☐ No

If yes, what is the name of the Facility? _____

How did you hear about Retina Health Center? ☐ Billboard/Building Signage ☐ Doctor ☐ Event

☐ Family/Friend ☐ Google/Online Search ☐ Other: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Primary Eye Physician: _____ Phone: _____

Address: _____ Fax: _____

Height: _____ **Weight:** _____

Ocular History:

☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	LASIK / Epi-LASEK
☐ Yes	☐ No	Cornea Transplant	☐ Yes	☐ No	Macular Degeneration
☐ Yes	☐ No	Diabetic Retinopathy	☐ Yes	☐ No	Punctal Plugs
☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No	Retinal Detachment
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	YAG Laser

☐ Other: _____

What is the reason for your visit today?

☐ Blurred Vision	RT LT	☐ Dry Eyes	RT LT	☐ Itching	RT LT
☐ Decreased Vision	RT LT	☐ Flashes	RT LT	☐ Pain	RT LT
☐ Discharge	RT LT	☐ Floaters	RT LT	☐ Red Eye	RT LT
☐ Double Vision	RT LT	☐ Headache	RT LT	☐ Tearing	RT LT

☐ Other: _____

Immunization / Vaccination:

☐ Yes ☐ No Influenza Date/s: _____

☐ Yes ☐ No Pneumococcal Date: _____

Surgical History:

☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	Hemorrhoidectomy
☐ Yes	☐ No	Carotid Endarterectomy	☐ Yes	☐ No	Hysterectomy
☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No	Mastectomy
☐ Yes	☐ No	Heart Bypass	☐ Yes	☐ No	Prostate
☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Skin Cancer Removal

☐ Other: _____

Allergies:

☐ Yes ☐ No Latex Please describe: _____

☐ Yes ☐ No Anesthesia Please describe: _____

Retina Health Center

1567 Hayley Lane, Suite 101 • Fort Myers, Florida 33907
(239) 337-3337 • Fax (239) 274-6610

2210 Vanderbilt Beach Road, Suite 1100 • Naples, Florida 34109
(239) 793-5200 • Fax (239) 514-7521

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History:

☐ Yes	☐ No	Cataracts	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Diabetes	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Glaucoma	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Macular Degeneration	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Retinal Detachment	☐ Mother	☐ Father	☐ Other: _____
☐ Other: _____			☐ Mother	☐ Father	☐ Other: _____

Social History:

Occupation: _____ ☐ Retired ☐ Disabled ☐ Not Working

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Walking ☐ Other: _____

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

Past / Present Medical History:

☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No	Hearing Loss
☐ Yes	☐ No	Alzheimer's	☐ Yes	☐ No	Heart Attack: Year _____
☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	High Blood Pressure/Hypertension
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Irregular Heart Beat
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No	Kidney Failure
☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Kidney Stones
☐ Yes	☐ No	Bruises	☐ Yes	☐ No	Migraine
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Nausea
☐ Yes	☐ No	Cardiovascular Disease	☐ Yes	☐ No	Parkinson
☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No	Psoriasis
☐ Yes	☐ No	COPD	☐ Yes	☐ No	Seasonal Allergies
☐ Yes	☐ No	Dementia	☐ Yes	☐ No	Sinus Problems
☐ Yes	☐ No	Depression	☐ Yes	☐ No	Skin Rashes
☐ Yes	☐ No	Diabetes: Type 1 or Type 2	☐ Yes	☐ No	Stroke: Year _____
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Stomach Ulcers
☐ Yes	☐ No	Hearing Aides	☐ Yes	☐ No	Thyroid Disease

☐ Other: _____

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MY LIST OF MEDICATIONS & DRUG ALLERGIES

Medical Record #: _____

Patient Name: _____ **Date:** _____

Preferred Pharmacy: _____

Pharmacy Address or Crossroads: _____

Current Medications: This list includes all prescribed medications, over-the-counter medications, vitamins and other supplements (herbal or non-traditional).

Medication Name	Dose (i.e. 100 mg)	Times / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)

Drug Allergies: This list includes all known drug allergies and type of reaction.

☐ No known drug allergies.

Medication Name	Type of Reaction

Medication Name	Type of Reaction