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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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: _____

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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: _____

Notice of Non-Discrimination & Interpreter Services

Retina Health Center, P.L. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity). Retina Health Center, P.L. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity).

Retina Health Center, P.L.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters;
    - Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters;
    - Information written in other languages.

If you need these services, contact our Compliance Officer/Section 1557 Coordinator.

If you believe that Retina Health Center, P.L. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with:

Compliance Officer/Section 1557 Coordinator
Retina Health Center, P.L.
8043 Cooper Creek Blvd
Suite 101
University Park, FL 34201
Phone: 941.373.6277
Fax: 941.373.6278
TTY number—711

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Retina Health Center
A US EYE COMPANY

Translation Services

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-856-0568.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 888-856-0568.

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-856-0568.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-856-0568.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-888-856-0568.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-856-0568.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-856-0568.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-856-0568.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-856-0568.

Arabic
إذا كنت تتحدث العربية ، تتوفر
خدمات المساعدة اللغوية
المجانية. اتصل بالرقم 888-856-0568.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-856-0568.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-856-0568.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화하십시오. 1-888-856-0568.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-856-0568.

Gujarati

જો તમે ગુજરાતી બોલો છો, તો મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. 1-888-856-0568 પર કૉલ કરો.

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-856-0568.

NOTICE OF PRIVACY PRACTICES

Retina Health Center, P.L.

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

OUR LEGAL DUTY:

Retina Health Center, P.L. 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, P.L. 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 January 15, 2026 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. We may tell you about any changes to our notice through a newsletter, patient portal, website or a letter.

You may request a copy of this notice (or any subsequent revision of this notice) at any time, even if you agreed to get this Notice by electronic means, you still have the right to ask for a paper copy. 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, P.L. 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, P.L. 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). If you receive services through Telemedicine, we will also collect information as part of the services or information provided during the audio and/or video teleconference encounter itself, and to the extent applicable, through other telephonic communications. We may also collect information from the electronic medical record system (if applicable) of your selected provider in order to facilitate the provision of services.

Payment: Retina Health Center, P.L. 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, P.L. 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. These activities also include care coordination, case management, quality assessment and improvement activities, to the extent permitted by law. 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.

Sharing your PHI with you. Retina Health Center, P.L. must give you access to your own PHI. You have the right to inspect and obtain a copy of your PHI in the form and format you request, including an electronic copy, if it is readily producible in that form and format. If the PHI is not readily producible in the requested form or format, it will be provided in a readable alternative form or format. We will act on your request for access no later than 30 days after receipt of your request, unless a lawful extension applies. Any fees charged will be reasonable and cost-based, as permitted by law. Retina Health Center, P.L., including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. The calls/texts may be about appointment reminders, appointment confirmations, treatment options, health-related benefits and services and to gather feedback regarding your experience. If you do not want to be contacted by phone or text, just let the caller know and we will add you to our Do Not Call list. We will then no longer call or text you. However, if you initiate communications using e-mail, we will assume (unless you have explicitly stated otherwise) that e-mail communications are acceptable to you. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. You understand you must take reasonable steps to protect against the unauthorized use of electronic communications by others, and Retina Health Center, P.L. is not responsible for breaches of confidentiality caused by you or an independent third party.

Retina Health Center, P.L. 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 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.

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, P.L. 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.

Accreditation Organizations: Disclosure to accreditation organizations for quality purposes. Any accreditation organization would be considered a Business Associate and would enter into an agreement with us to maintain confidentiality and protect the privacy of your PHI.

Disaster Relief: To respond to a disaster relief organization inquiry that seeks your PHI to coordinate your care or notify family or friends of your location or condition in a disaster.

USES AND DISCLOSURES OF PHI THAT REQUIRE YOUR AUTHORIZATION OR ATTESTATION

The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of PHI for marketing purposes; and
- Use and disclose genetic information of you or your dependents for underwriting purposes.

For certain kinds of PHI, federal and state laws may require enhanced privacy protection, and we can only disclose such information with your written permission except when specifically permitted or required by law. This includes PHI that is:

- Maintained in psychotherapy notes and mental health notes.
- About alcohol and drug abuse prevention, treatment and referral (except as permitted by 42 C.F.R. Part 2)
- About HIV/AIDS testing, diagnosis or treatment.
- About venereal and/or communicable diseases(s).

• About genetic testing.

Certain uses and disclosures of health information may be subject to additional restrictions under applicable federal or state law. Where such laws apply, Retina Health Center, P.L. will comply with those requirements.

You may revoke your authorization at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI
You have the following rights, subject to certain limitations, regarding your PHI:
• Inspect and obtain a copy of your PHI that is included in paper or electronic records we maintain. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
• Request restrictions in how the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by law to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply. Further, we will honor your request, to the extent permitted by law, not to disclose information to us, an insurer or a third party about a medical visit, service or prescription for which you pay the full amount out of your pocket at the time of service.
• Request an accounting of disclosures we have made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. 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 and will notify you in advance for responding to these additional requests.
• Request confidential communications whereby we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.
• Receive notice of a breach in the event of a breach of any of your PHI.
• Request an amendment of your PHI that you believe is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided below and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment and will inform you of the reason for the decision within 60 days.

Questions and Complaints:

If you want more information about our privacy practices or if you have questions or concerns, please contact Retina Health Center, P.L.**'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, P.L. 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:

Attention: Privacy Officer
Office: 8043 Cooper Creek Blvd
Suite 101
University Park, FL 34201
Email: useyecompliance@useye.com

You may also contact the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. Your complaint can be sent by email, fax, or mail to the Office of Civil Rights. U.S. Dept. of Health, OCR, 200 Independence Avenue SW, Washington, D.C., 20201. For more information, see their website at: http: www.hhs.gov/ocr/privacy/hipaa/complaints/.

No action will be taken against you for filing a complaint.

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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. I understand that I may be contacted via SMS text messages for appointment reminders, appointment confirmations, to gather feedback regarding my experience or with promotional offerings.

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

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

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. A 3% convenience fee will be applied to all credit card transactions. In addition, RHC offers financing options through third party vendors.

No Show/ Appointment Cancellation Policy: This policy is designed to help us serve all patients as effectively as possible.

To keep things running smoothly, appointments are necessary. When appointments are missed or cancelled late, it affects more than just our schedule—it limits the availability of care for other patients who could have used those time slots. These disruptions can lead to delays in healthcare for others.

If you need to cancel your appointment, please let us know at least 24 hours in advance. We understand that emergencies happen, but because missed appointments are becoming more common, we must strictly enforce this policy. Consistent no-shows without timely notice may result in a fee for each missed appointment or possible dismissal from our practice. Late arrivals may need to be rescheduled, and the missed appointment fee may apply. Please keep in mind that this fee is not covered by insurance.

We value your understanding and recognize that medical emergencies can happen unexpectedly. Each case will be reviewed individually.

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 Center. 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 the physicians at Retina Health Center, 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

EMAIL COMMUNICATION OF HEALTH INFORMATION
FACT SHEET AND CONSENT FORM

As a patient of Retina Health Center, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

PLEASE READ THIS INFORMATION CAREFULLY

Retina Health Center staff will make every effort to promptly respond to your requests for information via email, however, *if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention*.

Risks of using email to send protected health information include, but are not limited, to:

- **Risk of Unauthorized Access by a 3rd Party**: Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.

- **Unique Difficulty in Verifying the Sender**: Email may be easier to forge than handwritten or signed papers. Retina Health Center will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Procedures

- Emails are not checked outside of normal business hours – this includes overnight, on weekends or holidays.
- Please call Retina Health Center at 1-888-873-9348 to confirm that your request was received if you haven't received a response by email or telephone within 24-48 hours.
- If at any time you change your email address or wish to discontinue email communications altogether, you must notify Retina Health Center immediately in writing.

EMAIL COMMUNICATION OF HEALTH INFORMATION
FACT SHEET AND CONSENT FORM

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Retina Health Center harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Client Email Address:_____

Client Signature_____ Date of Birth:_____

Client Name (printed) _____Date: _____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

_____

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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