Retina CONSULTANTS OF WESTERN NEW YORK

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NEW PATIENT INFORMATION FORM

APPOINTMENT DATE: _____ **SOCIAL SECURITY#** _____

PATIENT NAME: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

DATE OF BIRTH: _____ **AGE;** _____ **MARITAL STATUS:** _____

PHONE #: _____ **CELL PHONE #:** _____

EMPLOYED BY: _____ **OCCUPATION:** _____

EMPLOYER ADDRESS: _____ **WORK PHONE:** _____

NAME OF SPOUSE OR PARENT: _____

EMPLOYED BY: _____ **WORK PHONE:** _____

REFERRING DOCTOR & PHONE: _____

MEDICAL DOCTOR & PHONE: _____

EMERGENCY CONTACT _____ **PHONE:** _____

TYPE OF INSURANCE: _____

I HEREBY AUTHORIZE MEDICARE TO FURNISH TO THE ABOVE NAMED DOCTOR ANY INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

_____ _____

SIGNATURE OF PATIENT **DATE**

Medication List

Patient Name _____ Date _____

(This list must be filled out every six months, expires _____)

Systemic Medications:

Please list all medications, vitamins, supplements that you are currently taking.

Medication	Dosage
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

Eye Medications: Please list all eye medications you are using, including all eye drops.

Eye Medication	Eye - left /right/both	Dose
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Reviewed with Patient

Date/Intials		

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print) _____ Medicare Number _____

1. **MEDICARE**: I request that payment of authorized Medicare benefits are made on my behalf to Retina Consultants of WNY, for services furnished me by Retina Consultants of WNY. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (Formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Retina Consultants of WNY accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP**: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Retina Consultants of WNY, if possible or otherwise to me.

3. **RELEASE OF INFORMATION**: Retina Consultants of WNY may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communication disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Retina Consultants of WNY for reimbursement for services rendered, and (2) any health care provider for continued patient care. Retina Consultants may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE**: I understand that Retina Consultants of WNY maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Retina Consultants of WNY has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Retina Consultants of WNY if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES**: I understand that Retina Consultants of WNY's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Retina Consultants of WNY to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by Retina Consultants of WNY, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Retina Consultants of WNY for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Retina Consultants of WNY. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Retina Consultants of WNY. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party _____ **Date** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
H.I.P.P.A Privacy Act

RETINA CONSULTANTS OF WESTERN NEW YORK

531 FARBER LAKES DRIVE
WILLIAMSVILLE, NY 14221

3055 SOUTHWESTERN BLVD
SUITE 108
ORCHARD PARK, NY 14127

6930 WILLIAMS ROAD
SUITE 3800, BLDG C
NIAGARA FALLS, NY 14304

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Relationship to Patient (if other than self) _____

Signature: _____ **Date**: _____

Designation of Personal Representatives:

I, _____, hereby designate the following as my personal representatives for purposes of all rights, obligations and responsibilities created under the HIPPA privacy rules.

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

I acknowledge and agree that Retina Consultants of WNY may disclose my protected health information to my personal representatives and that my personal representatives have the authority to authorize the practice to use and disclose my protected health information.

Signature: _____ **Date**: _____

Retina Consultants of WNY

Dr. Faruk M. Koreishi · Dr. Paul J. Lee · Dr. Mehdi Khan · Dr. Christopher Jermak

Patient Name: _____ **Chart** _____

Consent for Examination:

I hereby consent to such examination procedures as, in the judgment of my physicians, may be considered necessary or advisable while a patient of Retina Consultants of WNY. I recognize that my treatment and care could be observed and in some instances aided by physicians and/or technicians under supervision.

X_____ _____

Patient (or person authorized to sign for patient) **Date**

X_____ _____

Witness **Date**

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 if you make arrangements not to drive yourself.

X_____ _____

Patient (or person authorized to sign for patient) **Date**

X_____ _____

Witness **Date**
