Retina CONSULTANTS OF WESTERN NEW YORK

Faruk M. Koreishi, M.D., F.A.C.S.
Paul J. Lee, M.D.
Mehdi A. Khan, D.O., F.A.C.S.
Christopher M. Jermak, M.D.
Ramakrishna "Ram" Ratnakaram, O.D., M.D.

WELCOME TO OUR PRACTICE

This packet of information contains the necessary paperwork that will need to be completed prior to your visit. **Please bring all enclosed items**, **your insurance card, form of photo ID, co-payments and referrals** if needed with you to your scheduled appointment.

The following is a checklist of the items contained in the packet:

1. **Things to Note When Coming to Our Office** -This form lets you know what to expect during your visit.

2. **Red Flag Rules** – The Federal Trade Commission rule requiring verification of identity.

3. **New Patient Information Form** – Please complete all questions so you can be properly registered in our system.

4. **Initial Medical History (two (2) page form)** – This form provides a brief synopsis of your current medical health.

5. **Medication List** – Use this form to list all medications, vitamins and supplements you are taking.

6. **Notice of Privacy Practices Acknowledgement** - This form is acknowledgment of protected health information and allows you to designate others to have access to your health information.

7. **Professional Courtesy and Copays** – This letter provides our policy on professional courtesy and collection of copayments

8. **Signature of File, Assignment of Benefits, Financial Agreement Form** – This form is acknowledgement that you are responsible for payment of services rendered not covered by your insurance. Form must be signed even if you do not have Medicare.

9. **Consent for Examination and Information Regarding Dilating Eye Drops** – This form gives your consent to the examination and acknowledgement that both eyes will be dilated for the examination.

10. **HEALTHeLINK consent** – Patient consent form for health information exchange.

If you are unable to keep your appointment, please contact our patient centralized scheduling number **(716) 795-2010** to reschedule your appointment.

6637 Main Street ▪ Williamsville, New York 14221 ▪ 716-632-1595 ▪ FAX 716-204-4895
3055 Southwestern Boulevard, Suite 108 ▪ Orchard Park, New York 14127 ▪ 716-712-2440 ▪ FAX 716-712-2444
6930 Williams Road, Building C, Suite 3800 ▪ Niagara Falls, New York 14304 ▪ 716-205-0151 ▪ FAX 716-205-0155
WEB SITE: www.wnyretina.com

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THINGS TO NOTE WHEN COMING TO OUR OFFICE

You will be at our office for approximately 2-3 hours, and longer if you have procedures done the same day.

You will need a driver to bring you to your appointment and to return you home. Your pupils will be dilated in both eyes leaving your close-up vision blurry for approximately 3-4 hours after the exam.

PLEASE BRING THE FOLLOWING WITH YOU:

> A list of medications that you currently take along with the dosages.
> A list of any surgeries that you have had.
> Please bring your glasses. In addition, bring a pair of sunglasses or clip-ons if you have them.
> Please bring your insurance cards, form of photo ID, copayment and referral if applicable.

IF YOU ARE A DIABETIC, PLEASE BRING A SNACK WITH YOU!!!

We submit to any and all insurance for you.

We **DO** participate with the following insurances:
> Aetna
> BlueCross BlueShield of WNY/ Senior Blue / Community Blue
> Empire Plan
> Fidelis
> GHI
> Independent Health / Encompass 65
> Medicaid
> Medicare
> United Healthcare
> Univera

If you have any questions regarding anything prior to your appointment, please contact our office and we will be happy to assist you.

WE THANK YOU AND WELCOME YOU TO OUR PRACTICE

Medical and Surgical Management of Vitreo-Retinal Diseases

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Retina CONSULTANTS

Red Flag Rules

IMPORTANT INFORMATION FOR PATIENTS

Effective May 1, 2009

The FTC Red Flag Rules require every practice to establish an Identity Theft Prevention Program to detect, prevent and mitigate identity theft by obtaining, verifying and recording information that identifies each patient.

WHAT THIS MEANS FOR THE PATIENT

We will ask for your name, address, date of birth and other information that will allow us to identify you. You will be asked to present a copy of your:

Driver's license (or other Photo ID)
Current health insurance card

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NEW PATIENT INFORMATION

Appointment Date: ________________ Social Security Number: ____________________

Patient Name: ____
(Last) (First) (Middle)

Address: ____________________________ City: _____________ State: ___ Zip: ________

Home phone: ______________ Cell phone: ______________ Work phone: ____________

Date of Birth: _______________ Age: _______ Sex: ____ Male ____ Female

Marital Status: _________________ Email: ____________________________________

Employer: _________________________________ Occupation: _____________________

Employer Address: ____

Referring Physician: ____

Primary Care Physician: ____

Emergency Contact: _________________________________ Phone: _________________

Pharmacy: ____ Phone: _________________

Primary Insurance: _________________ ID#: _________________ Group #: __________

Secondary Insurance: _________________ ID #: _________________ Group #: __________

Third Insurance: _________________ ID #: _________________ Group #: __________

Guarantor/Spouse's Social Security Number: ______________ Guarantor's Date of Birth: _______

I hereby authorize Medicare to furnish to the above named physician(s) any information regarding my Medicare claims under Title XVIII of the Social Security Act. I, also, hereby authorize Retina Consultants of WNY to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

______________________________________ ______________________
Signature of patient Date

Initial Medical History

Name ______________________________ Date ______________

Date of birth ____________________ Date of last eye exam ______________

List any **medications** you currently take [prescriptions, and over-the-counter]

____

____

Do you have **allergies** to any medications? ☐ YES ☐ NO
If YES, list the medications:

____

____

List all **major illnesses** [glaucoma, diabetes, high blood pressure, heart attack, etc] or **injuries** [concussion, etc.]:

____

____

List any **surgeries** you have had [cataract, tonsillectomy, appendectomy], and provide date or duration and which eye:

____

____

What is your **main problem or chief complaint** regarding your eyes? Please check any of the boxes below that further describes your problem.

____

____

	YES	NO	Explanation of Problem
EYES [Glaucoma, cataract, retinal disease, etc.]			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted visions [halos]			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid [blepharitis, stye]			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT [Sinus, ear infection, chronic cough, dry mouth, etc.]			
CARDIOVASCULAR [Heart, vessels, etc.]			
RESPIRATORY [Asthma, emphysema, etc.]			
GASTROINTESTINAL [Stomach ulcers, intestinal disease, etc.]			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS [Arthritis, etc.]			
SKIN [Acne, warts, skin cancer, etc.]			
NEUROLOGICAL [Multiple sclerosis, etc.]			
PSYCHIATRIC [Anxiety, depression, insomnia]			
ENDOCRINE [Diabetes, hypothyroid, etc.]			
BLOOD/LYMPH [Cholesterolemia, anemia, etc.]			
ALLERGIC/IMMUNOLOGIC [Hay fever, lupus, Sjogrens, etc.]			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: ______________________

Education [High school, Vocational school, College degree]: ______________________

Marital Status [Married, Divorced, Single, Widowed]: ______________________

Living Arrangements: ______________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with nigh vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses? ______________________

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? ______________________

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO If YES: occasional 1/2 pack/ day 1 pack/day 1+ pack

Are you pregnant? ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO

☐ YES ☐ NO

History reviewed. ☐ No Changes ☐ Additions as noted above

Physicians Signature: ______________________ 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		

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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

RETINA CONSULTANTS OF WESTERN NEW YORK

6637 MAIN STREET
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 Act of 1996 (H.I.P.A.A.), 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 H.I.P.A.A. privacy rules.

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

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: ______________

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RE: PROFESSIONAL COURTESY AND COPAYS

To Our Colleagues and Patients:

Professional Courtesy and the routine waiver of non-collection of deductibles and copayments have been identified by the Office of the Inspector General (OIG) as a fraud and abuse risk area. To extend those courtesies is to invite scrutiny from the OIG and risk civil monetary penalties and exclusion from federal healthcare programs. To this end, we will no longer extend professional courtesy, no longer be able to waive or decline copayments, accept assignment unless allowed by your insurance company, or write off any charges without evidence of financial hardship. Thank you for your continued support and cooperation.

Sincerely,

RETINA CONSULTANTS OF WNY

Medical and Surgical Management of Vitreo-Retinal Diseases

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Signature on File, Assignment of Benefits, Financial Agreement

Patient Name (Print) ____________________ Insurance ID# ____________________

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 (CMS) 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 CMS-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 non-covered services. Coinsurance and deductible amounts 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 CMS-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, communicable 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 of WNY may also disclose on any 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., HMO's, PPO's) 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 the 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, deductibles or coinsurance 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.

Patient Signature or Authorized Party ____________________ **Date** ____________________

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CONSENT FOR EXAMINATION and DILATING EYE DROPS

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 ______________________________________ Date: ______________
Patient (or person authorized to sign for patient)

X ______________________________________ Date: ______________
Witness

....

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 the 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 ______________________________________ Date: ______________
Patient (or person authorized to sign for patient)

X ______________________________________ Date: ______________
Witness

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Patient Consent to Participate in HEALTHeLINK Health Information Exchange

I understand that if I give Consent below, I am allowing Western New York Clinical Information Exchange ("HEALTHeLINK") to release and provide access to all of my Medical Information to my health care providers and health insurers who are treating me, that I am enrolled with, or that are making payments for my health care and are participating now or in the future in HEALTHeLINK. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me" or "my" refer to the Patient.

1. **Purpose:** I understand that my Medical Information disclosed to HEALTHeLINK will be used only to provide me with medical treatment and to assess and improve the quality of medical care delivered by my health care providers.
2. **Types of Information:** I understand that this Consent permits access to **all** of my available Medical Information, including but not limited to, sensitive information related to the following:
   - HIV/AIDS
   - Genetic Disease or Genetic Tests
   - Sexually Transmitted Diseases
   - Mental Health
   - Alcohol or Drug Abuse Treatment
   - Family Planning/Reproductive Care
3. **Electronic Health Information Sources:** Information accessed through HEALTHeLINK comes from a variety of sources ("Electronic Health Information Sources"). These Electronic Health Information Sources may include participating providers, other health care providers (such as pharmacies and clinical laboratories), health insurers, the New York State Medicaid program and other health information exchanges. A complete list of current Electronic Health Information Sources may be found at www.wnyhealthelink.com. This list will change from time-to-time as HEALTHeLINK continues to grow.
4. This Consent permits access to Medical Information created both before and after the date I sign this form. I understand that information about me may be re-disclosed only to the extent permitted by applicable laws and regulations. I understand that if I give consent, my consent will remain in effect until the day I withdraw consent or HEALTHeLINK stops operating, whichever comes first.
5. I understand that Health Insurers will have access to Medical Information for Disease Management, Case Management and Quality Improvement purposes. Health Insurers will not use this information for claim or coverage determination.
6. I understand that if I change my mind and wish to withdraw consent, I can sign a Withdrawal of Consent form. If I withdraw consent, access will no longer be available to Medical Information about me through HEALTHeLINK unless and until I again give consent by signing and completing a new Consent form. The withdrawal of consent will not affect the exchange of my Medical Information made while my Consent was in effect.
7. I understand that if I Deny Consent below, there will be no access to my Medical Information through HEALTHeLINK, except in an emergency.
8. I understand that the decision to participate in HEALTHeLINK is voluntary. No participating HEALTHeLINK health care provider will deny me medical care and my insurance eligibility will not be affected if I Deny Consent to participate.
9. I understand that I can access a list of participating HEALTHeLINK health care providers and health insurers by either going to www.wnyhealthelink.com or by calling 716-206-0993 to have the most current list of providers sent to me either by fax or mail.
10. I understand that de-identified data (no one will be able to identify me personally) may be used by HEALTHeLINK for research and evaluation purposes.
11. I understand that I will get a copy of this form after I sign it.

I hereby: ☐ Give Consent; or ☐ Deny Consent **(Check One Box Only)**

RETINA CONSULTANTS
716-632-1595
Entity Consent Received By

Printed Name of Patient **Date of Birth**	**Signature of Minor (if between the ages of 12 and 18)** **Date**
Signature of Patient or Patient's Legal Representative **Date**	**Print Name of Patient's Legal Representative (if applicable)**
Address/City/State/Zip Code of Patient	**Authority to sign on behalf of patient (e.g., health care agent, guardian, parent)**

If you are NOT completing this form in a provider's office, you must have a witness who can verify your identity complete the information below:

Printed Name of Witness	**Relationship of Witness to Patient (e.g., spouse, son, neighbor)**
Signature of Witness **Date**	

2568 Walden Avenue, Suite 107, Buffalo New York 14225 / Dedicated Fax Line: 716-206-0039

HEALTHeLINK