RETINA
SPECIALISTS OF TAMPA

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Patient name: ______________________ DOB: __________ Race: ________ SSN: __________
Address: ______________________ City: __________ State: ______ Zip code: __________
Home phone number: ______________________ Cell phone number: ______________________
Email address: ______________________ Preferred method of contact: __________________
Relationship Status: (Please circle below)

Single Married Divorced Widowed

Employment Status: (Please circle below)

Employed Unemployed Disabled Retired Student

Current employer: ______________________
Primary Insurance Company: ______________________
Secondary Insurance Company (if applicable): ______________________
Emergency contact name: ______________________ Phone number: ______________________
Relationship to patient: ______________________ Can we share your medical information with them? Y / N
Preferred pharmacy: ______________________ Phone number/Address: ______________________

HOW DID YOU HEAR ABOUT US?

Referring physician name (if applicable): ______________________

Please circle, if applicable: Internet (website) Facebook Friend Advertising

Primary care provider name: ______________________

By my signature I authorize any holder of medical information about me to be released to my primary care physician or any other physician, hospital, ancillary facilities in order that I may be provided continuity of care. (A copy may be used in place of the original signature). Furthermore, I understand my signature requests that payment be made to the physician and authorizes release of medical information to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of Medicare. Physician or suppliers may assign other insurance payment and may not necessarily accept as full payment the amount paid by the other insurance company. The same applies for other insurance companies other than Medicare. Although the staff at Seashore verifies eligibility before providing services it is my responsibility to pay any unpaid claims. I, the Guarantor, understand that I am fully responsible for payment of services provided. I will pay any balance due that insurance does not cover or pay. I will pay all expenses incurred by this office. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including but not limited to reasonable attorney's fees, that we may incur in such collection efforts.

Patient Signature: ______________________________________ Date: ______________

CANCELLATION POLICY

Please be advised that if you need to cancel your appointment for any reason, we must have 48 hours notice in order to avoid a cancellation fee. We have a waiting list for patients that wish to have their appointment sooner and enough time is needed to move them into your vacant spot. $25.00 is the charge for a missed appointment not canceled 48 hours prior to the scheduled time. Much time and effort goes into scheduling an appointment, we ask that you make every preparation possible to keep your appointment date. We apologize in advance if this policy causes you any inconvenience.

Patient Signature: ____ Date: ____________

Patient Printed Name: ____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to 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 over a span of a couple hours, but the length of time 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. Since driving may be difficult immediately after an examination, it is best if you make arrangements not to drive. Adverse reaction, such as acute angleclosure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

By signing below, I authorize Dr. Tarabishy/Dr.Dunn and/or such associates as may be designated by him/her to administer dilating eye drops. I understand that the dilating eye drops are necessary to diagnose my condition.

Patient Signature: ____ Date: ____________

Witness: ____ Date: ____________

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognizes your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of the patients. You may request a copy of the full text of this law from your healthcare provider or health care facility. A summary of your right and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual identity, and with protection of his or need for privacy
- A patient has the right to a prompt and reasonable response to questions and requests
- A patient has the right to know who is providing medical services and who is responsible for his or her care
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English
- A patient has the right to know what rules and regulations apply to his or her conduct
- A patient has the right to be given, by the healthcare provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis
- A patient has the right to refuse any treatment, except as otherwise provided by law
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care
- A patient who is eligible for Medicare, has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- A patient has the right to receive a copy of reasonably clear and understandable, itemized bill, and upon request, to have the charges explained
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him or her and to the appropriate state licensing agency
- A patient is responsible for providing ,to the healthcare provider, to the best of his or her knowledge, accurate and complete information and present complaints, past illnesses, hospitalizations, medications, and other matters relation to his or her health
- A patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider
- A patient is responsible for reporting, to the healthcare provider, whether she or her comprehends a contemplated course of action and what is expected of him or her
- A patient is responsible for following the treatment plan recommended by the healthcare provider
- A patient is responsible for his or her actions if her or she refuses treatment or does not follow the healthcare provider's instructions
- A patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct

Patient Signature: ______________________________ Date: ______________

RETINA SPECIALISTS OF TAMPA: NOTICE OF PATIENT PRIVACY PRACTICES

This describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is effective as of March 1, 2013 and applies to all protected health information as defined by federal and state regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and fro you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care/treatment. This information, referred to as your health or medical record may be use by your practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professional who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the county, state and nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits ▪ We may use your information for appointment reminders as defined by the "Consent" page

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy of your health record electronically as provided for in 45 CFR 164.524 (HIPPA)
- Amend your health record as provided in 45 CFR 164.524 (HIPPA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of certain uses and disclosures of your information to health plans, if you fully paid for these services out-ofpocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have the right to opt out of communications of fund raising activities of the practice

OUR RESPONSIBILITIES, WE ARE REQUIRED TO:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a request restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in the reception area. At your request, we will provide you with a revised "Notice of Patient Privacy Practices". **TO REPORT A PROBLEM**

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe you privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the U.S Department of Health and Human Services. There will be no retaliation for filing a complaint.

TREATMENT, PAYMENT AND HEALTH OPERATIONS

Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information may be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate(s) so they can perform the job we have hired them to do. HIPPA now requires the business associate, their agent, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page.)

Communication with Family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care, as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents there of health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Seashore Retina's "Notice of Privacy/Policy", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the consents of the Notice and I request the following restrictions(s) concerning the use of my personal medical information. If you have no restriction requests, please leave the space below, blank.

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By signing below, I am stating that I have read and understood all privacy protocols set by Retinal Specialists of Tampa

Patient Signature: ____ Date: ______________

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTH INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/Aids status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment, and/or healthcare.
- To request, from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment for services or treatment we provided to you,
- To leave appointment reminders or other minimum necessary information related to your healthcare payments on your answering machine, mobile voice or text mail, email or with a household family member.

☐ Please check here if you do **not** want us to leave messages on your answering machine or with a household family member

☐ Please check here if you do **not** want us to leave a message on your mobile voice/text mail

☐ **Please check here if your authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary, in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare treatment or payment information:

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RETINA
SPECIALISTS OF TAMPA

PATIENT REGISTRATION FORM

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

- You may request a copy of and you have the right to read our "Notice of Patient Privacy/Practices" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I FULLY UNDERSTAND AND AGREE TO THIS AUTHORIZATION AND ACKNOWLEDGE THE ABOVE RIGHTS AND DISCLOSURES

FOR OFFICE USE ONLY. Patient refused to sign the form.
Reason: ________________________________ Date: _______________

Patient Signature: ____ Date: _______________

Printed Patient Name: ____

Printed Name of Person Signing (If not the patient): ____

Relationship to patient: ____

*If someone other than the patient is signing, are you the parent, legal guardian, legal custodian, or have a Healthcare Power of Attorney for the patient? (Circle which is applicable) Y / N