



Excellence
Compassion
Vision

Retina Group of Florida
New Patient Medical History

Ronald J. Glatzer, MD
Barry S. Taney, MD
Lawrence S. Halperin, MD
W. Scott Thompson, MD
Patrick E. Rubsamen, MD
Scott R. Anagnoste, MD
Krista Rosenberg, MD
Mandeep S. Dhalla, MD

Patient Name: _____ Date of Birth: _____ Date: _____

Family/Primary Doctor/Internist: _____ Eye Doctor: _____

List all Medications (including Aspirin and EYEDROPS) you currently take: _____

Do you have ALLERGIES to any medications or eyedrops? YES NO
If YES, list the medications: _____

List all MEDICAL Problems: _____

List all EYE Problems: _____

List all SURGERIES or LASER TREATMENT you have had (cataract, gall bladder, etc.): _____

Have you ever been hospitalized? YES NO
If YES, list reason and all dates: _____

PAST EYE HISTORY
CIRCLE ALL THAT APPLY

GLAUCOMA LAZY EYE
FLOATERS GLARE
CATARACT EYE INJURY
RETINAL DETACHMENT
FLASHING LIGHTS
DISTORTION NONE

MEDICAL PROBLEMS

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc)			
General (fever, fatigue, weight loss, weight gain, etc)			
EARS, NOSE, THROAT (hearing, dry mouth, dizziness, nosebleeds, difficulty swallowing, hoarseness, etc)			
HEART / VESSELS (high blood pressure, headaches, racing pulse, fainting, heart attack, chest pains, carotid surgery, etc)			
RESPIRATORY (short of breath, wheezing, asthma, chronic cough, lung cancer, emphysema, Tuberculosis, etc)			
GASTROINTESTINAL (stomach ulcers, reflux, diarrhea, constipation, hernia, jaundice, blood in stools, etc)			
GENITOURINARY (painful urination, frequent urination, bloody urine, impotence, dialysis, HIV, hepatitis C, syphilis, etc)			
ORTHOPEDIC (joint pain or stiffness, joint swelling, gout, muscle cramps, arthritis, etc)			
SKIN (rashes, warts, pimples, mouth ulcers, painful skin nodules, café au lait spots, tick bites, etc)			
NEUROLOGIC (seizures, numbness, stroke, paralysis, etc)			
PSYCHIATRIC (anxiety, claustrophobia, depression, etc.)			
ENDOCRINE (diabetes, thyroid gland, etc.)			
BLOOD (bleeding, high cholesterol, anemia, blood transfusions, leukemia, lymphoma etc.)			
IMMUNE (HIV, Lupus, hives, itchy skin, eczema, etc.)			
FEMALES (history of breast cancer, are you pregnant? Nursing?)			

Family History: MOTHER, FATHER, GRANDPARENTS, SIBLINGS, CHILDREN

CIRCLE ALL THAT APPLY

CATARACT GLAUCOMA DIABETES NIGHT BLINDNESS
RETINAL DETACHMENT MACULAR DEGENERATION
CANCER ARTHRITIS HEART ATTACK STROKE

NONE

Social History:

Smoke cigarettes? _____ packs per week NO
Drink alcohol? _____ drinks per week NO
Drive an automobile? YES NO
Had a blood transfusion? YES NO

FOR OFFICE USE ONLY

The above history has been completely reviewed by _____, MD _____ Date

Updated _____, MD _____ Date Updated _____, MD _____ Date Updated _____, MD _____ Date

Updated _____, MD _____ Date Updated _____, MD _____ Date Updated _____, MD _____ Date

PATIENT INFORMATION

Cell Phone # (____) _____

Patient Name: _____ / _____ / _____ Phone # (____) _____
(Last Name) (First Name) (MI)

Guardian (if patient is a minor): _____ / _____ / _____
(Last Name) (First Name) (MI)

Florida Address: _____ Apt. # _____
(Street)

_____ / _____ / _____
(City) (State) (Zip)

Is this a Skilled Nursing Facility or Rehabilitation Facility? Yes / No

Alternate Address: _____

Birthday: _____ Social Security #: _____ Sex: M / F

Primary

Insurance: _____ ID #: _____

Policy Holder's Name: _____ Relationship: _____

Customer Service Phone #: _____

Secondary

Insurance: _____ ID #: _____

Policy Holder's Name: _____ Relationship: _____

Customer Service Phone #: _____

Employer: _____ Phone #: _____

Spouse's Name: _____ Birthday: _____

Emergency Contact: _____ Phone #: _____

Referring Eye Doctor: _____

_____ / _____ / _____
(Phone #) (City) (State)

Primary Care Doctor: _____

_____ / _____ / _____
(Phone #) (City) (State)

Please Sign Reverse Side

**Patient Authorization to Release and/or Receive Information
For the Purpose of Claim Payment.**

I hereby authorize Retina Group of Florida, RGF physicians, and/or any RGF employees or agents to release any information regarding services rendered and allow a photocopy of my signature to be used to collect for services and file claims to my insurance company. I hereby give permission to contact any party listed on this form or in my medical chart to verify insurance, credit, or personal information. We want you to know that our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to always take reasonable precautions to protect your privacy, and want you to know that we support your full access to your personal medical record. I understand that I am responsible for my health insurance co-payments, deductibles, co-insurance, and any non-covered services at the time services are rendered.

Patient Signature (Guardian Signature if Patient is a Minor)

Date

Print Patient Name

Witness

LIFETIME AUTHORIZATION

***Medicare and Medicaid Patient Certification – Authorization to
Release Information and Payment Request.***

I certify that the information given by me in applying for payment under the TITLE XVII, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient Signature

Date

Print Patient Name

Witness



*Excellence
Compassion
Vision*

Barry S. Taney, MD
Lawrence S. Halperin, MD
W. Scott Thompson, MD
Patrick E. Rubsamen, MD
Scott R. Anagnoste, MD
Krista D. Rosenberg, MD
Mandeep S. Dhalla, MD
Kevin T. Kelly, MD

PUPIL DILATION

Information and Consent

Correspondence

Fort Lauderdale

5601 N. Dixie Hwy,
Suite 307
Fort Lauderdale, FL 33334
FAX: 954-776-6895
TEL: 954-776-6880

Boca Raton

950 Glades Rd.
Suite 1-C
Boca Raton, FL 33431
FAX: 561-391-6004
TEL: 561-394-6499

Boynton Beach

8190 Jog Rd.
Suite 250
Boynton Beach, FL 33472
FAX: 561-737-8335
TEL: 561-737-1355

Hollywood

4000 Hollywood Blvd.
Suite 190-N
Hollywood, FL 33021
FAX: 954-894-4822
TEL: 954-894-7020

Plantation

1776 N. Pine Island Rd.
Suite 312
Plantation, FL 33322
FAX: 954-452-2027
TEL: 954-452-4500

A portion of the complete eye examination which is performed in our office includes pupil dilation. This is essential for evaluation of your retinal condition. Pupillary dilation requires the placement of eyedrops which may last several hours.

Dilation creates difficulty focusing on near objects or reading material. Dilation may cause driving an automobile or operating heavy machinery to be dangerous.

Dilation of the pupils may rarely cause acute glaucoma. Signs include redness, severe pain, nausea, or loss of vision. If this occurs after dilation, please call our office immediately.

By signing below, I understand the above and give my consent for pupil dilation during my visits to this office.

Patient Name

Date



FINANCIAL AGREEMENT & ENDORSEMENT AUTHORIZATION

The fee for service is an obligation of the patient and is due at time of service. If you have medical insurance, our staff will assist you in obtaining the full allowable benefits from you insurance company. However, in the event the insurance company refuses previously confirmed coverage or reimburses a lesser amount than charged, the patient is fully responsible for the entire obligation. Any service not covered by your insurance company must be paid at the time of service.

I fully understand that I am directly and fully responsible to Retina Group of Florida for all medical bills submitted by RGF, or its agents, for services rendered to me. I further agree to allow Retina Group of Florida to release any information necessary to process any medical claims rendered on my behalf. I further authorize payment of medical benefits to Retina Group of Florida for services rendered. I have read the above and fully understand its contents and all of my questions have been answered. I hereby agree to render payments in accordance with the terms and conditions set forth, and agree to pay collection fees, interest, court and attorney fees in order to collect any outstanding balances.

I (we) the undersigned, hereby authorize Retina Group of Florida and its agents to endorse by (our) name, any medical drafts received from third party payers.

Authorized Signature _____

Date _____

Print

Name _____ Relationship _____ Witness _____



Excellence
Compassion
Vision

RETINA GROUP OF FLORIDA
HIPAA COMPLIANT MEDICAL AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION

To whom it may concern:

I, _____, _____
Name Address, City, State, Zip Code

hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to

Name Address, City, State, Zip Code

Name Address, City, State, Zip Code

regarding my complete medical history and physical & mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time. The person(s) named above is/are hereby designated as my "personal representative(s)" as that term is used within HIPAA.

I intend the person(s) listed above to have authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under Illinois law.

Signature of person authorizing disclosure:

Date

Witnessed on the date noted above by:

Signature of witness #1 Signature of witness #2

Print name of witness #1 Print name of witness #2

Witnesses should not be any of the persons listed above or heirs of mine.

You may refuse to sign this authorization form.

HIPAA Notice of Privacy Practices

[Name]

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____