Retina Vitreous Associates of Florida

Scott Pautler, MD
Steven Cohen, MD
Karina Findlay, MD
David Eichenbaum, MD
Alfred White, MD
Ashley Crane, MD
Priya Vakharia, MD
Palak Patel, MD
1-888-MACULA-1 (888-622-8521)

Please fill out completely

Legal Name

First: _____ **Middle:** _____ **Last:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____

DOB: _____ **Sex:** _____ **SS #:** _____ **Marital Status:** M S W D

Ethnicity: Hispanic Non-Hispanic Unknown **Race:** Asian African American White American Indian Other

2nd Address: _____ **Type:** _____

City: _____ **State:** _____ **Zip:** _____

Insurance Information

Primary: _____ **ID#:** _____ **Relation:** **Self** **Spouse** **Child** **Other**

Subscriber **Name:** _____ **DOB:** _____ **SS#:** _____

Secondary: _____ **ID#:** _____ **Relation:** **Self** **Spouse** **Child** **Other**

Subscriber **Name:** _____ **DOB:** _____ **SS#:** _____

Physician Information

Referred by: _____ **Phone #** _____

Address: _____

Primary MD: _____ **Phone #** _____

Address: _____

Name: _____ **Relation:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Guarantor (MUST be filled out if patient is a minor!)

First: _____ **Middle:** _____ **Last:** _____

Address: _____ **Relation:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

DOB: _____ **Sex:** _____ **SS #:** _____ **Marital Status:** **M** **S** **W** **D**

Ethnicity: Hispanic Non-Hispanic Unknown **Race:** Asian African American White American Indian Other

I authorize the physicians and staff of Retina Vitreous Associates of Florida to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date: _____

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COMPREHENSIVE INFORMATION FOR OFFICE VISIT

(Chief Complaint and History of Present Illness)

(Note: If you have several problems, please ask for a separate sheet for each problem.)

What is the main problem that brings you to the office today?		
Please describe the symptom; right eye / left eye?		
When did it start? How long have you had this problem?		
Did the problem come on quickly or slowly?	Quickly	Slowly
Please describe:		
Did anything seem to cause or bring on the problem?		
Is the problem always there or does it come and go?	Always there	Comes & goes
Is there anything that makes it better or worse?	Yes	No
If yes, please describe:		
How severe is the problem? (You can describe how it bothers you or describe it as mild, moderate or severe.)		
Has the problem changed in any way since it first came on?	Yes	No
Same / Better / Worse; More Often / Less Often:		
Have you had this problem before or have you received a diagnosis?	Yes	No
If yes, please describe:		
Additional Information:		

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MEDICAL HISTORY

Current eye medications: _____

VISION HISTORY:

Past eye problems & date of onset: _____

Past eye surgeries with dates: _____

PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)

RT	**LT**	Lazy Eye since birth	**RT**	**LT**	Burning
RT	**LT**	Eye glasses @ child / adulthood	**RT**	**LT**	Feels like sand/lash in eye
Date last updated: _____			**RT**	**LT**	Eye Discharge
RT	**LT**	Eye Injury: Type: _____	**RT**	**LT**	Tearing Eye
RT	**LT**	Blind Spot in vision	**RT**	**LT**	Eye Redness
RT	**LT**	Straight lines appear crooked/wavy	**RT**	**LT**	Eye Pain
RT	**LT**	Floating Spots/Cobwebs	**RT**	**LT**	Itchy
RT	**LT**	Loss of side vision	**RT**	**LT**	Matted eyes upon awakening
RT	**LT**	Droopy lid	**RT**	**LT**	Excessive light sensitivity
RT	**LT**	Glare or Halos	**RT**	**LT**	Bulging Forward of eyes
RT	**LT**	Foggy/Cloudy vision	**RT**	**LT**	Double vision
RT	**LT**	Blurring of vision:	**RT**	**LT**	Rapid flashing lights (Strobe)
Circle one or both: Distance / Near			**RT**	**LT**	Yellow tinted vision

Do you take aspirin, Advil or other over the counter pain medicines? YES or NO

List: _____

Do you take dietary supplements or herbal supplements? ***YES or NO***

List: _____

Current Medications / Dosages **Associated medical condition / # of years**

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

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Family History

	Age:	Living:	Medical problems or Cause of Death:
Mother:	_____	Y N	_____
Father:	_____	Y N	_____
Siblings:	_____	Y N	_____
	_____	Y N	_____

Please check the box for each condition that applies to your relative and indicate the relationship:

F: Father **M**: Mother **S**: Sister **B**: Brother **GP**: Grandparents **C**: Children **O**: Aunts/Uncles

Check:		Relative:	Check:		Relative:
_____	Glaucoma:	_____	_____	Diabetes:	_____
_____	Macular Degeneration	_____	_____	Cancer:	_____
_____	Retinal detachment	_____	_____	Heart Disease:	_____
_____	Retinitis Pigmentosa	_____	_____	Stroke:	_____
_____	Blindness at birth	_____			

Social History

Please Circle the correct answer:

Do you drive? YES or NO

Do you drive at night? YES or NO

Do you have pets or animal exposure? YES or NO

If YES, what type of animals? _____

Do you use tobacco products? YES or NO

If YES, Type and frequency: _____

Call 1-800-QUITNOW for free help and information on stopping tobacco.

Do you drink alcohol beverages? YES or NO

If YES, how frequently? Drinks/day? _____

Do you use any recreational drugs? YES or NO

If YES, Type of drugs and frequency: _____

Do you eat undercooked meat or fish? YES or NO

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OCCUPATIONAL HISTORY

Are you currently employed? YES or NO

Current Employer:

Name: _____

Address: _____

What is/was your occupation? _____

Do you feel safe at home? YES or NO

Are you in a relationship in which you are being hurt or threatened emotionally or physically?
Call the Domestic Abuse Hotline 1-800-500-1119 for help.

Marital Status: M S W D

Do you have a Power of Attorney: YES or NO
With Whom:_____

Can medical information be left with family members? YES or NO

I have completed this medical history to the best of my ability:

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date: _____

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General Patient / Physician Agreement

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

Confidentiality:
In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

Financial Policy:
I authorize Retina Vitreous Associates of FL to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Retina Vitreous Associates of FL to release medical information for insurance purposes. I authorize payment to be made directly to Retina Vitreous Associates of FL if an assignment is indicated by my insurance company. As a courtesy, Retina Vitreous Associates of FL will contact insurance companies for authorization for services required. Retina Vitreous Associates of FL is not responsible for lapses of insurance or for incorrect information.

Patient/Guardian Initials: _____

Failure to Follow Physician Orders:
"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness or failure to attend follow-up appointments. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices:
As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. (Dated 2016)

I have received a copy of Retina Vitreous Associates of FL's Notice of Privacy Practice.

Patient/Guardian Initials: _____

Scheduling Policy:

I understand that I may be seen by any Retina Vitreous Associates of Florida physician, not necessarily my regular or preferred doctor, based on office location, schedule, and the urgency of my problem. RVAF will always attempt to schedule routine office visits with the physician of choice.

Patient/Guardian Initials: _____

Consent for Pupil Dilation:
As part of your comprehensive eye examination, it may be necessary to dilate your pupils at each visit. Dilation can temporarily affect your vision, particularly but not limited to your ability to focus on close objects and your sensitivity to light. It is your responsibility to ensure that you can safely leave our facility after your appointment, whether that means arranging transportation or taking other precautions. By initialing below, you acknowledge that the physician and the practice are not liable for any incidents that occur once you leave our care.

Patient/Guardian Initials: _____

Patient's Signature:

Patient/Guardian Signature: _____ Date: _____

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Notice of Privacy Practices Receipt of Acknowledgment

Retina Vitreous Associates of Florida

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Retina Vitreous Associates of Florida has a Notice of Privacy Practices and that the undersigned has had the opportunity to review this notice.
- Retina Vitreous Associates of Florida reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but Retina Vitreous Associates of Florida does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- Retina Vitreous Associates of Florida may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire and that the full Notice of Privacy Practices is available on our website at www.RetinaVitreous.com.

Patient/Guardian Initials: _____

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date:_____

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AUTHORIZED REPRESENTATIVE FORM HIPAA

Note: This form is used to confirm a patient's permission that RVA and its employees may discuss or disclose their protected health information to a designated person who acts as the patient's Authorized Representative. Use of their information is strictly limited to that purpose described above.

Section A: Patient Information
By signing this form in Section E below, I understand and agree that RVA of FL may release my personal health information as defined in Section B below to my Authorized Representative(s) named in Section C below.

Patient Name (*last, first, mi***):**_____

Address:_____

Telephone Number:_____ **Patient Chart ID Number:**_____

Please Note: This authorization does not provide your "Authorized Representative" with any authority; either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner, a clinical personal health care representative or a living will, please discuss this with your primary care physician or your attorney.

Section B: Type of Information
- Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, prescriptions, appointments and other demographic information (but not including any psychotherapy notes)

Section C: Authorized Use and / or Disclosure
Intended Use or Disclosure:
I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating the coordination of my healthcare. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name *(last, first, mi)***:** _____

Phone Number:_____

Address:_____

Relationship to You:_____

Authorized Representative #2:

Name *(last, first, mi)***:** _____

Phone Number:_____

Address:_____

Relationship to You:_____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure:

_____

_____

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire the first of every calendar year.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization **in writing** by giving written notice of my decision to my providers office contact. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request. I understand that, by signing this form, I am confirming my authorization that RVA and its employees may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above. I understand that I must renew this authorization every year.

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____

Signature:_____ **Date:**_____