



**RETINA ASSOCIATES  
OF FLORIDA, P.A.**

Diseases and Surgery of the Retina and Macula

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**PATIENT DATA SHEET – MUST BE COMPLETED IN FULL AND SIGNED**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Second Address: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone at second address: \_\_\_\_\_ Drivers License No.: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Do you currently live in a **Skilled Nursing Facility** or are you currently under the care of Hospice?  
Yes / No If yes, please name the facility: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about RAF? (Please circle one):

Friend / Internet / Phonebook / Radio/ Newspaper / Other: \_\_\_\_\_

My doctor referred me: Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

In order to protect your health information, please answer the following questions.

1. Please list any family members or persons, if any, whom we may inform about your general medical condition and your diagnosis.

\_\_\_\_\_ Relationship\_\_\_\_\_

\_\_\_\_\_ Relationship\_\_\_\_\_

\_\_\_\_\_ Relationship\_\_\_\_\_

\_\_\_\_\_ Relationship\_\_\_\_\_

2. May confidential messages be left on your home answering machine or voicemail?

Yes \_\_\_\_\_ No\_\_\_\_\_

3. May we communicate with you via email?

Yes \_\_\_\_\_ No\_\_\_\_\_

- ✓ I, the undersigned, have insurance with the above named company (ies) and I assign directly to Retina Associates of Florida, P.A. all benefits payable to me for services rendered. If Retina Associates of Florida, P.A. is a participating provider for my insurance company, I agree to pay any charges deemed as my responsibility by my insurance company. I authorize the release of any protected health information that is necessary to process my insurance claim.
- ✓ I, the undersigned, hereby authorize any physician who has examined me to release any and all protected health information and medical records to Retina Associates of Florida, P.A.
- ✓ I, the undersigned, hereby authorize Retina Associates of Florida, P.A. to provide and acquire medical information for patient care, patient follow-up and/or anonymous release for clinical study purpose.
- ✓ I, the undersigned, hereby authorize examination and treatment as deemed necessary or desirable by my attending physician including, but not limited to topical and systemic medication, fundus photography, fluorescein angiography, indocyanine green angiography, pneumatic retinopexy, laser therapy, cryotherapy, periocular injections, retrobulbar injections performed by the doctors and/or other qualified designates of Retina Associates of Florida, P.A. The risks, benefits and alternatives will be explained to me prior to the performance of any surgical procedures or invasive tests.
- ✓ I understand and have been provided a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures.
- ✓ Patients that contact our office or send inquiries via email should be advised that email messages are not a guaranteed confidential communication as they may be intercepted or read by unauthorized persons.
- ✓
- ✓

Signature:\_\_\_\_\_

Date:\_\_\_\_\_



Thank you for choosing Retina Associates of Florida. Our goal is to provide patients with the highest quality health care. To help ensure this, we have established this Financial Policy, which contains our requirements for payment of our services. You can assist us in keeping costs down by ensuring we are reimbursed for services in a timely manner. If you have any questions regarding this policy, please feel free to call our Billing Manager at 875-6373, extension 228. **If you are unable to comply with this policy at the time of service your appointment may be rescheduled.**

**Usual and Customary Rates:** Our practice is committed to providing quality, affordable care. Our charges are within what is usual and customary for our geographic area. However, you are responsible for payment regardless of your insurance company's determination of usual and customary rates.

**Patients With Health Insurance**

If you have health insurance and you provide us with complete and accurate information, it is our policy to file your insurance claim as a courtesy to you. In return, we ask that you pay, at the time you check in, any co-pay, cost-share, deductibles and patient balances.

We make every effort to collect benefits from insurance carriers. Although most insurers make payment in a timely manner, we may ask you to contact your insurance company when payment is not made within a reasonable time period.

If you elect to have a procedure deemed "non-covered" by your insurance company, you will be responsible for the costs associated with it. When we receive payment from your insurance company, we will bill you for any remaining portion of our charge(s).

If payment from your insurance carrier is not received within 45 days, we may hold you responsible for the full balance.

**Please make certain we always have current information about you and your insurance coverage.**

**Patients Without Health Insurance or With Health Insurance For Which We Are Not Providers**

If you do not have insurance, or if we are not a provider for your insurance plan, payment in full is due on the day of service as follows:

▪ **Office Visits:** We will ask you to pay the total charges for services provided on the day of service.

▪ **Surgery and In-Office Procedures:** We will ask you to pay the full amount due for surgeries and in-office procedures as follows:

- **In-Office Procedures:** Full payment is due on the day the procedure is performed.
- **Non-Emergency Surgery:** Payment is due no later than the day before surgery is performed.

**Patients Who Miss Appointments**

Appointment times are in great demand and we manage our schedules very carefully to schedule patients at times convenient to them. We will call you the day before each appointment to remind you of the time. If you are unable to keep an appointment, we prefer that you notify us at least 24 hours in advance.

This way, we can reschedule your appointment and make that time available to another patient.

If you miss more than three appointments during one month and do not notify us, we may charge you a \$25 fee.

***We want your experience to be a pleasant one! Please do not hesitate to call us if you have any questions or concerns.***

I hereby acknowledge that I have read and understood the Financial Policy of Retina Associates of Florida, P.A. and agree to comply with all aspects of the policy that pertains to me.

Signed \_\_\_\_\_

Date \_\_\_\_\_



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## **REFUND POLICY**

Dealing with insurance companies is sometimes confusing and almost always complicated. If you have any questions about our Financial Policy or about a refund that you believe is due or a refund check you receive, please call our Billing Department for assistance at 875-6373.

### **Patient Payments**

If we are a provider for your insurance company, at the time you check in, you will be asked to pay any co-pay, cost-share, co-insurance, deductible and balance due. After your visit is complete, we file a claim with your insurance company.

If we are not a provider for your insurance plan we expect payment in full on the date of service.

### **Insurance Company Payments**

Once a claim has been filed, it is up to the insurance company to determine when, how much and to whom payment will be made. In some cases, an insurance company will respond promptly and pay our practice within as little as three weeks with one check.

In other cases, it could take as much as a year to receive payment from an insurance company, depending on the type of services provided, other claims that have been filed on your behalf and the insurance company's policy, at a given point in time, for reimbursement.

We sometimes receive multiple checks for one patient's claim over an extended period of time. Whenever we receive what we believe is partial payment we research the matter to determine if that is all the insurance company will pay or if they are making multiple payments.

There are also times when the insurance company determines that it will not make any payment at all.

As you can imagine, it is sometimes difficult to determine exactly when an insurance company has made its final payment on a claim. For this reason, we are careful not to take any action regarding refunds until we have some assurance that final payment has been made. Once we believe final payment has been made, we use the following guidelines for making refunds.

### **Refunds**

We research any credits and overpayments and refund amounts due to the appropriate payor. If you are due a refund, we will issue your check timely.

I hereby acknowledge that I have read and understood the Refund Policy of Retina Associates of Florida, P.A.

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Patient Signature

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Date



**MEDICAL HISTORY AND INFORMATION - PLEASE FILL OUT COMPLETELY**

**PATIENT HISTORY:**

Please check the appropriate choice of the medical problems that you have:

Recent weight change	yes/no	Loss of appetite	yes/no	Stroke/TIA	yes/no
Fever	yes/no	Abdominal pain/heartburn	yes/no	Head Injury	yes/no
Headaches	yes/no	Peptic ulcer	yes/no	Confusion/memory loss	yes/no
Eye injury/disease	yes/no	Nausea/Vomiting	yes/no	Nervousness	yes/no
Do you wear glasses	yes/no	Blood in Urine	yes/no	Depression	yes/no
Blurred/double vision	yes/no	Kidneys Stones	yes/no	Diabetes	yes/no
Glaucoma	yes/no	Female #pregnancies _____		(insulin dependent, no insulin)	
Hearing loss/ringing	yes/no	#miscarriages _____		duration of diabetes _____	
Nose bleeds	yes/no	Joint pain	yes/no	Hemoglobin A1c _____	
Swollen glands in neck	yes/no	Back pain	yes/no	Thyroid disease	yes/no
High Blood Pressure	yes/no	Difficulty walking	yes/no	Bleeding/bruising	yes/no
(controlled or uncontrolled)		Rash/Itching	yes/no	Anemia	yes/no
duration _____		Change in skin color	yes/no	Enlarged lymph glands	yes/no
Chest pain / angina	yes/no	Varicose veins	yes/no		
Heart palpitation	yes/no	Frequent headaches	yes/no	OTHER DISEASE OR ILLNESS:	
Shortness of breath	yes/no	Convulsions/Seizures	yes/no	_____	
Swelling feet/ankles	yes/no	Tremors	yes/no	_____	
Asthma / wheezing	yes/no	Paralysis	yes/no		

Please list any eye surgery or laser surgery, including dates and physician's/surgeon's name.

Please list all medications that you take, including eye drops:

Please list any allergies to medications that you may have:

Please list all major surgeries, including approximate dates:

**Family History:**

Please check the appropriate choice if anyone in your immediate family has had the following conditions:

_____ Macular Degeneration	_____ Diabetes	_____ Cancer
_____ Retinal Detachment	_____ Heart Disease	_____ Glaucoma

**Social History:**

Do you smoke? \_\_\_ Yes \_\_\_ No If yes, how much \_\_\_\_\_

Do you drink alcohol? \_\_\_ Yes \_\_\_ No If yes, how much \_\_\_\_\_

Any history of drug abuse? \_\_\_ Yes \_\_\_ No

Do you live \_\_\_\_\_ Alone \_\_\_\_\_ With Spouse \_\_\_\_\_ Other

Do you work? \_\_\_ Yes \_\_\_ No \_\_\_\_\_ Retired Occupation \_\_\_\_\_

**To be completed by office personnel:**

Eye Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ UPIN: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ UPIN: \_\_\_\_\_



# RETINA ASSOCIATES OF FLORIDA, P.A.

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## NOTICE OF PRIVACY PRACTICES

**This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.**

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Retina Associates of Florida, P.A. is dedicated to protecting the privacy of your health information. Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your 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 make more informed decisions when authorizing disclosure to others. We are required by law to maintain the confidentiality of your health information in keeping with the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Retina Associates of Florida, P.A. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims payment or coordination of benefits and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records. There may be some services provided in our organization through contracts with Business Associates. Examples include, but are not limited to, laboratory tests, compilation of photographic slides, and patient satisfaction surveys. When these services are contracted, we may disclose some or all of your protected health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, we require the Business Associate to appropriately safeguard your information.

Retina Associates of Florida, P.A. is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Examples of such include, but are not limited to, public health requirements or court orders. Retina Associates of Florida, P.A. will not make any other use or disclosure of a patients protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

Retina Associates of Florida, P.A. may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Unless otherwise required by law your health record is the physical property of Retina Associates of Florida, P.A., however, the information belongs to you. Patients have the following rights with respect to their protected health information that may be exercised. Individuals have the right to request restrictions on certain uses and disclosures of protected health information. Retina Associates of Florida, P.A. is not required to agree to a requested restriction. Individuals have the right to receive confidential communications of protected health information, inspect and copy protected health information, amend protected health information, receive an accounting of disclosures of protected health information, and revoke authorization to use or disclose health information except to the extent that action has already been taken.

Retina Associates of Florida, P.A. will abide by the terms of this notice or the notice currently in effect at the time of the disclosure. Retina Associates of Florida, P.A. also reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices. Retina Associates of Florida, P.A. will provide each patient with a copy of any revisions of its Notice of Privacy Practices at the time of their next visit or at their last known address if there is a need to disclose any protected health information of the patient. Retina Associates of Florida, P.A. will post the most current version of our notice on our website.

Any person may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: 602 S. Mac Dill Avenue, Tampa, FL 33609, 813-875-6373. All complaints will be addressed immediately. No retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

For further information, please contact Michelle Hawes-Holmes, Administrative Assistant, at 813-875-6373, extension 226.

Notice effective February 21, 2003.

[PRINT](#)

[EMAIL](#)