Retina Care Group

New Patient Welcome Letter

Thank you for selecting Retina Care Group, Inc. for your retinal eye care needs. The following information is provided to ensure a smooth transition into our practice.

Please complete the forms and bring them with you to your first appointment to help speed up the check in process. You will need to arrive 15 minutes prior to your appointment time so that we are able to have your chart ready by your appointment time. We work hard to provide prompt, courteous service which includes dilation. **Please be sure to have a driver, sunglasses, and plan for up to a two hour visit** to allow ample time for dilation, and any necessary testing and / or treatment needed.

Please bring the following items with you for your visit:

- [ ] Current Insurance Card
- [ ] Valid Photo Identification Card
- [ ] Glasses

If you have time to complete the following items, please bring them with you:

- [ ] Completed New Patient Packet Forms Patient Information
    - [ ] Demographics
    - [ ] Financial Acknowledgement
    - [ ] HIPAA Compliance Consent Form
    - [ ] Practice Privacy Notice
    - [ ] Dilation Consent
    - [ ] Medical History
    - [ ] Medical Release Form

All copayments are collected at the time of check in. For self-pay patients, payment in full at the time of service is required, unless discussed otherwise. We accept cash, checks, and all major credit cards.

Thank you! We look forward to meeting you soon.

Sincerely,

Marc Estafanous, MD & Staff
Retina Care Group, Inc
350 Sharon New Castle Rd
Farrell, PA 16121
Left Entrance
724-248-2020

Retina Care Group

DEMOGRAPHICS

Name (Last, First, Middle): _____ Phone: (_____)_____

SSN: _____-_____-_____ DOB: _____ Can we leave a message? ☐ Yes ☐ No

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Marital Status: ☐ Married ☐ Single ☐ Widowed

Emergency Contact: _____ Emergency Contact Phone: (_____)_____

Occupation: _____ ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Island

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's DOB: _____

Secondary Insurance Co: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's DOB: _____

I request that payment of authorized Medicare and / or insurance benefits be made on my behalf to Retina Care Group, Inc. for any and all services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

_____ _____

Patient Signature / Legal Representative Date

_____ _____

Patient Signature / Legal Representative Date

PHYSICIAN INFORMATION

Eye Doctor: _____ Phone: (_____)_____

Primary Care Doctor: _____ Phone: (_____)_____

Other Doctor: _____ Phone: (_____)_____

Preferred Pharmacy: _____ Phone: (_____)_____

Retina Care Group

FINANCIAL ACKNOWLEDGEMENT

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, testing and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand that **all copayments are due at the time of service and will be collected on the day of your visit.**

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office with both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____

Print Patient Name / Legal Representative

_____ _____

Patient Signature / Legal Representative Date

Retina Care Group

HIPAA Compliance Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

_____

Print Patient Name / Legal Representative

_____ _____

Patient Signature / Legal Representative Date

Retina Care Group

PRACTICE PRIVACY NOTICE

Our policies for protecting your healthcare information is explained in our Notice of Privacy Practices. We have and are required to provide you with a copy. This notice states how we may use and / or disclose your health information. Please sign below, and list personal contacts in whom we may share your health information with. We can ONLY speak to the contacts listed below.

Print Name /Relationship	Phone Number
_____	(_____)_____
_____	(_____)_____
_____	(_____)_____

By signing below, I have acknowledged that I have received a copy of Retina Care Groups Notice of Privacy Practices.

_____

Print Patient Name / Legal Representative

_____ _____

Patient Signature / Legal Representative Date

FOR OFFICE USE ONLY

We have made great effort to obtain written acknowledgement of our Notice Of Privacy, but it could not be obtained due to the following:

- ☐ The patient refused to sign
- ☐ Due to emergency situation patient unable to sign
- ☐ Office was unable to communicate with the patient
- ☐ Other: _____

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DILATING CONSENT

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 your 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. **Please note, you will not be able to have any medically necessary procedures done without a driver. You understand your appointment will be canceled / rescheduled to a day when you can have one available.**

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Estafanous and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Print Patient Name / Legal Representative

_____ _____

Patient Signature / Legal Representative Date

Retina Care Group

MEDICAL HISTORY

Reason for Visit: _____

_____

_____

Any Current or Past Medical Problem:

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Disease

☐ Heart Disease ☐ Autoimmune Disease ☐ Anemia ☐ Cancer _____

☐ Other: _____ _____ _____

Allergies to Medications: _____ _____

List All Current Medication: _____ _____

_____ _____ _____

_____ _____ _____

Surgeries / Year: _____ _____

_____ _____ _____

EYE HISTORY

Please check if any of the following pertains to your eye health.

☐ Cataract ☐ Glaucoma ☐ Refractive Surgery ☐ Macular Degeneration

☐ Retinal Detachment ☐ Retinal Tear ☐ Diabetic Retinopathy ☐ Vein Occlusion

☐ Eye Injections (Type/Number/Last Date): _____ ☐ Other: _____

OTHER HISTORY

Please check all that apply:

☐ Trouble Hearing ☐ Chest Pain ☐ Numbness/Tingling ☐ Easy Bleeding/Bruising

☐ Night Sweats ☐ Headaches ☐ Confusion ☐ Weight Loss

Any Family Medical Problems: _____ _____

Do you smoke? ☐ Yes ☐ No

Retina Care Group

MEDICAL RELEASE FORM

Date: _____

Patient Name: _____ Phone: (_____)_____

SSN: _____-_____-_____ DOB:_____

Address: _____ City: _____ State: _____ Zip: _____

Please release medical records to:
Retina Care Group, Inc.
350 Sharon New Castle Rd
Farrell, PA 16121
Phone Number: 724-248-2020
Fax Number: 724-936-2021

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, to release any and all information pertaining to my medical care.

Practice Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Description of information to be released:

- ☐ Ophthalmology records
- ☐ History & physical
- ☐ Operative report
- ☐ Lab results
- ☐ Demographic sheet
- ☐ Other: _____

_____

Print Patient Name / Legal Representative

_____ _____

Patient Signature / Legal Representative Date