Central Triad Retina

3333 Brookview Hills Blvd, Ste 107 | Winston-Salem, NC 27103
o 336.970.5900 f 336.842.3964
CentralTriadRetina.com

Name:	Date:
Appointment Date:	Time:

PLEASE COMPLETE THE ENCLOSED MEDICAL HISTORY QUESTIONNAIRE AND PATIENT INFORMATION FORMS:

- ☐ **Bring a list of all medications** and eye drops you are currently using or taking.
- ☐ **Bring your insurance cards.** Make sure all referrals are current if required.
- ☐ **Return all information** in the self-addressed, stamped envelope or bring the completed information with you at your scheduled appointment.

IMPORTANT

- **Your eyes will be dilated.** This will cause your vision to be blurry. Please **bring a friend or family member** to drive you home after your appointment.
- Please allow **at least 2 hours** for your appointment.

From all of us at Central Triad Retina, we look forward to providing you with the highest quality care and customer service possible.

Please let us know if you have any questions about your appointment, or the care you will be receiving.

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New Patient History Information

Name: Today's date

Birthdate: Patient ID#:

Social Security #: Referring physician:

Address:

City: State: Zip:

Home phone: Cell phone:

Work phone: Other:

Emergency contact: Relationship:

Emergency contact phone:

Note: When you provide a wireless telephone or landline number, you are giving us consent to call that number.

Check one:

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Check one:

☐ Employed ☐ Retired ☐ Student ☐ Unemployed

Employer name:

Employer phone:

Employer address:

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New Patient History Information continued

Primary insurance company name:

Insured name: Policy #:

Insured Social Security #: Group #:

Relationship to patient: Insured birthday:

Employer: Work phone:

Other insurance:

Company: Policy #: Group #:

Please allow us to photocopy your insurance card.

Insurance Information

Payment for services rendered is to be made as follows:

I request that payment of authorized insurance benefits be made to **Central Triad Retina**. This practice is limited to treatment for disease of the retina and vitreous. I authorize payment for any services, medications and/or medical supplies provided in my treatment. I authorize **Central Triad Retina** to release to the Health Care Financing Administration (HCFA/CMMS), my insurance Carrier and/or its agent's appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with the HIPPA guidelines. **I am financially responsible for appropriate deductibles, copayments, and non-covered items** (this information has been supplied to me by my carrier). If this account is delinquent for non-payment, the account may be turned over to a collection agency. I will be responsible for all costs of collection including the court costs and reasonable attorney fees.

	Date signed:
Patient or responsible party signature:	Relationship to patient:

continued

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Medical History

Name:	Today's date
Birthdate:	Date of last eye exam:
Describe the problems you are experiencing with your eyes:	
Reason for your visit:	Physician treating you:
Do you wear eyeglasses: ☐ Yes ☐ No	Do you wear contacts: ☐ Yes ☐ No How long?

Current Eye Problems	Right Eye	Left Eye	Both Eyes	Describe Briefly
Blind spot				
Burred vision				
Straight lines appear crooked or wavy				
Floating spots/cobwebs				
Foggy/cloudy vision				
Loss of side vision				
Decreased vision				
Eye discharge				
Eye pain				

Past Eye Problems	Right Eye	Left Eye	Both Eyes	Describe Briefly
Flashes or floaters				
Vision loss (sudden or gradual)				
Cataract surgery				
Other eye surgery				
Laser treatment				
Eye injury				
Macular degeneration				
Retinal tear or detatchment				
Amblyopis (lazy eye)				
Optic nerve disease				
Other				

Please check **Yes** or **No** and describe briefly

☐ Yes ☐ No Diabetes, _____ years AIC _____ date _____
☐ Yes ☐ No High blood pressure, _____ years
☐ Yes ☐ No Arthritis/inflammatory joint disease_____
☐ Yes ☐ No Ear/nose/throat disorder _____

continued

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Medical History continued

☐ Yes ☐ No Heart disease _____
☐ Yes ☐ No Lung disease _____
☐ Yes ☐ No Digestive or gastrointestinal disease _____
☐ Yes ☐ No Kidney disease _____
☐ Yes ☐ No Urinary tract disease _____
☐ Yes ☐ No Neurological disorder or stroke _____
☐ Yes ☐ No Thyroid disease _____
☐ Yes ☐ No Skin cancer or disorder _____
☐ Yes ☐ No Cancer or blood disorder _____
☐ Yes ☐ No Allergies _____
☐ Yes ☐ No HIV/AIDS, your CD4 viral count?_____ Year diagnosed _____
☐ Yes ☐ No Hepatitis _____ Year _____
☐ Yes ☐ No Psychiatric problems _____
☐ Yes ☐ No Significant weight loss or gain in last year _____
☐ Yes ☐ No Are you pregnant? Months _____
☐ Yes ☐ No Have you ever had a blood transfusion? Year _____

List all surgeries and approximate dates:

List all medications, including dose. If you have a list, you may bring it with you.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Are you on blood thinners (anticoagulant)? ☐ Yes ☐ No Name:

Do you take aspirin daily? ☐ Yes ☐ No Dosage:

List eye drops that you are currently using:

1.	4.
2.	5.
3.	6.

List all drug allergies

1.	4.
2.	5.
3.	6.

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to adhesives? ☐ Yes ☐ No

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Medical History continued

Family History

Has any member of your family had these diseases?

	Yes	No	Relationship
Blindness			
Cataract			
Glaucoma			
Diabetes			
High blood pressure			
Heart disease			
Stroke			
Cancer			
Thyroid disease			
Arthritis			
Other			

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Signature on File
Assignment of Benefits, Financial Agreement

Print name: _____ Medicare #:_____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Central Triad Retina**. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Central Triad Retina**. Charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the Form-1500/(0212) or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Central Triad Retina** if possible, or otherwise to me.
3. **RELEASE OF INFORMATION: Central Triad Retina** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to **Central Triad Retina** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Central Triad Retina** may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that **Central Triad Retina** maintains a list of health care service plans with which it contracts. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **Central Triad Retina** if I belong to a plan that does not appear on the above mentioned list.

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5. **NON-COVERED SERVICES:** I understand that **Central Triad Retina** contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient, and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **Central Triad Retina** to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **Central Triad Retina**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Central Triad Retina** for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to **Central Triad Retina**. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Central Triad Retina**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient signature
or authorized party: _____ Date: _____

Relationship: _____

continued

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Acknowledgment of Receipt of Privacy Notice

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.

I have been presented with a copy of Central Triad Retina's Notice of Privacy Practices. I understand that I have the right to request restrictions concerning the use of my medical information. I requested the following individual(s) be restricted: _____

_____

Notice of information Practices

1. **Central Triad Retina** may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool or sports physicals, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims, including coordination of benefits with other insurers and/or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance, including auditing records.
2. **Central Triad Retina** is permitted or required to use or disclose protected health information within the individual's written consent or authorization in certain circumstances. Two examples of such are public health requirements or court orders.
3. **Central Triad Retina** will not make any other use or disclosure of a patient's protected health information without the individual's written consent. Such authorization may be revoked at any time. Revocation must be in writing.
4. **Central Triad Retina** will abide by the terms of this notice currently in effect at the time of the disclosure.
5. **Central Triad Retina** reserves the right to change terms of it notice and to make new notice provisions effective for all protected health information that it maintains. **Central Triad Retina** will provide each patient with a copy of any revision of its Notice of Information Practices at the time of their next visit, or at the last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record.
8. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

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9. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request, and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
10. Any patient, guardian or personal representative has the right to request restriction as to how their health information may be used or disclosed to carry out treatment, payment, or healthcare operations. **Central Triad Retina** is not required to agree to the restrictions requested, but if **Central Triad Retina** does agree, **Central Triad Retina** must abide by those restrictions.
11. Any person/patient may file a complaint to **Central Triad Retina** and to the **US 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:
3333 Brookview Hills Blvd., Winston-Salem, NC 27103.
Office phone 336.970.5900. Fax 336842.3964.
12. **All complaints will be addressed and the results will be reported by the Privacy Officer.**
13. It is the policy of **Central Triad Retina** that 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.

Effective date_____ Name of patient_____

Signature of patient or
legal guardian_____Date: _____

Notice of Information Practice
Acknowledgment of Receipt of Privacy Notice

If patient or patient's representative refuses to sign acknowledgment of receipt of notice, document the date and time of notice and sign below.

Presented on:_____Time: _____

By: _____Name & title