AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE INITIAL) (LAST)

The purpose of this release form is to authorize Highland Retina Associates, LLC to make disclosures of Protected Health Information (PHI) to specific individuals who are involved in your care. Such information includes, but is not limited, to diagnosis, procedures, treatment plans, test results, appointments, and billing information including account balances, payments and payment arrangements, and insurance claims status.

Note: If you do not wish to release any health information, please check here and sign at the bottom:

- I do not authorize the release of health information.

I authorize Highland Retina Associates, LLC to release any personal information relating to my care to:

_____
NAME

_____ _____
RELATIONSHIP PHONE NUMBER

_____
NAME

_____ _____
RELATIONSHIP PHONE NUMBER

I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

- No restrictions.
- With the following restrictions _____
  _____

I understand that it is possible that information used or disclosed with my permission could be disclosed by the recipient and thus would no longer be protected by the federal HIPPA Privacy Rule.

I understand that this authorization remains in effect unless it is revoked. I understand that I have the right to revoke this authorization at any time, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing. My written revocation must be submitted to the Privacy Officer for Highland Retina Associates, LLC.

I understand that this disclosure is voluntary. I do not need to sign this authorization form to receive treatment.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
(PRINTED NAME IF LEGAL GUARDIAN) RELATIONSHIP TO PATIENT

HIGHLAND RETINA ASSOCIATES

INFORMATION REGARDING DILATING YOUR EYES

Dilation is an important part of a complete eye exam. Dilation will make your pupils **(the black part in the center of your eye)** large so that **Dr. Alexander Izad**, can get a better look at the back of the eye. Dilation is very useful in the detection of any serious eye diseases or physical changes that may threaten your vision.

The dilation will make reading things up close difficult, and make lights seem brighter than usual. These symptoms will usually only last for 3-5 hour; however, it can last longer in some people. Most people will be able to drive once their eyes are dilated, as long as they have sunglasses (which we can provide if you didn't bring any). However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver.
Please note: if your eyes are not dilated on the day of the visit we will be unable to do a retinal exam and your visit will be rescheduled.

Print Name: _____

Patient Signature: _____

Date: _____

FINANCIAL / CREDIT POLICY

The physician and staff of Highland Retina Associates, LLC are dedicated to the best possible care for you, and we want you to understand our financial policies. If you have questions regarding this document, please call our billing department at (812) 281-2608.

At Check-in: You must present your insurance card (s) for each visit.

Co-Payments: Co-payments are due and payable when you arrive. We accept cash, check, or VISA, MasterCard, Discover and American Express credit cards.

Referrals/Authorizations: Although we strive to verify all insurances prior to any appointment; It is your responsibility to ensure that we participate with your insurance carrier and whether or not you need a referral or authorization for the visit or procedure.

High Deductible Plans: When you arrive, you will be expected to pay any coinsurance, deductible and/or copay toward the visit and services for that day. If you need financial assistance, this needs to be discussed with the office prior to being seen. You will receive a statement for any remaining balance after we have submitted a claim to your insurance. If your payment results in a credit balance, we will refund that amount to you.

Balance Due: Balances are due either when you arrive at your next appointment or upon receipt of your first statement, whichever comes first. Failure to pay your balance will place you at risk of being discharged from our practice and having your account forwarded to a collection agency. Additional fees may apply to accounts that are forwarded to a collection agency.

No Fault or Workers' Compensation: You are responsible for providing your No Fault or Workers' Compensation information at the time of your arrival. Failure to provide this information will place your account in self-pay status and you will be responsible for all charges.

Self-Pay Patients: If you are without insurance, please contact our billing department at (812) 281-2608 prior to your visit to arrange payment terms. If you are having surgery, we will give you an estimate of the charges at the time of your visit. You will be asked to sign a self-pay contract and payment arrangement prior to your surgery.

Thank you for respecting this financial policy.

I have read this document and understand and agree to all the terms and conditions.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

(PRINTED NAME IF LEGAL GUARDIAN) (RELATIONSHIP TO PATIENT)

NO SHOW POLICY

Due to the doctor's specialty and an increased demand for his services, we will be implementing a new no show policy. We do understand that things happen that may cause you to miss an appointment; however, we do request that the patient or a family member calls our office at 812-281-2608 to cancel or reschedule the patient's appointment PRIOR to the appointment time, failure to do so will result in the following charges:

After 2 no shows within a 1-year period the patient will be charged a $10 fee.

After 3 no shows within a 1-year period the patient will be charged a $20 fee.

After 4 no shows within a 1-year period the patient will need to obtain a new referral from an Optometrist/ Ophthalmologist and there will be a $25 fee.

After obtaining a new referral and a patient no shows a 5th time within a 1-year period the patient will be charged $25.

After the 6th no show with a 1-year period the patient may be subject to dismissal from Highland Retina Associates. The dismissal will be determined by the physician, in accordance with Highland Retina Associates guidelines.

*Please note Medicaid patients will not be charged the no show fees, however, the re-referral and discharge policy still applies.

4621 E MARGARET DR TERRE HAUTE IN 47803
P 812-281-2608 F 812-281-2610

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE INITIAL) (LAST)

By signing below, I acknowledge that I have received Highland Retina Associates, LLC's Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
(PRINTED NAME IF LEGAL GUARDIAN) RELATIONSHIP TO PATIENT

Office Use:

This acknowledgement page should be retained in patient record. If acknowledgement could not be obtained from the patient, the reason(s) must be documented below:

_____ PATIENT DECLINED

_____ OTHER REASON (DESCRIBE BELOW):

_____

_____

_____

_____

_____ _____
EMPLOYEE SIGNATURE DATE

_____

EMPLOYEE PRINTED NAME

Highland Retina Associates LLC

PATIENT INFORMATION SHEET

□Mr. □Mrs. □Ms. First Name: _____ MI: ____ Last Name: _____

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

Patient's Date of Birth: _____ Age: _____ Sex: _____ Today's Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Social Security Number: _____

Race: _____ Language: _____ E-mail:_____

Receive appointment reminders via: EMAIL TEXT PHONE CALL (You can select up to 3)

Employed: **Y N** (if yes) Full time Part-time Self Retired Military Occupation: _____

PRIMARY INSURANCE INFORMATION: ☐ **Commercial** ☐ **Medicaid** ☐ **Medicare** ☐ **Self Pay**

Insurance Company: _____ ID#: _____ GROUP#: _____

Insured's Full Name:_____ **DOB**:_____ **SSN#:** _____

Relationship to Patient: Self ____ Spouse____ Child____

SECONDARY INSURANCE INFORMATION: **PLEASE NOTE WE DO NOT ACCEPT RETRO ACTIVE MEDICAID**

Insurance Company: _____ ID#: _____ GROUP#:_____

Insured's Full Name:_____ **DOB:**_____**SSN#:** _____

Relationship to Patient: Self _____ Spouse _____ Child____

Preferred Pharmacy: _____ ***Town:*** _____***Phone #:***_____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Address: _____

REFERRING PHYSICIAN: **FAMILY PHYSICIAN:**

Name: _____City:_____ Name: _____ City: _____

PLEASE READ AND SIGN BELOW

I hereby authorize the physician and staff of Highland Retina Associates LLC to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physicians during any and all visits to HRA, I understand that I am financially responsible for ALL charges arising from services rendered to me by HRA.

Signature: _____ Date: _____HRA Doctor_____

History Reviewed by: _____M.D. _____Date

Highland Retina Associates LLC

RELEASE OF INFORMATION:

I hereby authorize Highland Retina Associates LLC to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

I permit a copy of this authorization to be in place of the original.

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Highland Retina Associates LLC.

I further hereby authorize payment directly to HRA, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to HRA for changes not covered by this authorization.

I will cooperate in seeking, collecting, and paying to HRA, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to HRA, I agree to collect payment and pay to HRA with in five (5) days of receipt. Unless prior arrangements have been made regarding payment to Highland Retina Associates LLC.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

The Following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Highland Retina Associates LLC to share my protected health information with (not including other doctor offices):

_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.
_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.

Patient History Questionnaire

Highland Retina Associates LLC

Patient Name: _____ Today's Date: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Reason for visit:

Previous eye conditions and surgeries:

Current Eye Drops/ Frequency:

Medical:

____ **No Medical History**

Influenza vaccine received Yes No

Pneumonia vaccine received Yes No

Allergies: Chronic Seasonal

Alzheimer's/ Dementia

Anemia/Bleeding disorder

Arthritis / Rheumatoid

Cancer: _____

Chest Pains

COPD

Diabetes: Type 1 Type 2 Gestational

Hemoglobin A1C level _____

Heart Attack

Heart Condition: _____

Heart Disease/Vascular disease

Hepatitis: A B C

Herpes Virus: Cold Sores/ Shingles

High Cholesterol

High Blood Pressure

HIV/AIDS

Kidney Disease/ Dialysis/ Failure

Liver Disease

Long Term/ Current Steroid Use

Lung Disease/ TB

Lupus

Melanoma

Meningitis

Migraine

Multiple Sclerosis

Pneumonia

Pregnant

Psychiatric Disorder

Recent Chemotherapy Treatment

Recent fall

Radiotherapy Treatment

Seizures

Sickle Cell

Sleep Apnea

Stroke/TIA (Transient Ischemic Attack)

Syphilis

Temporal Arteritis/ Polymyalgia Rheumatica

Terminal Illness: _____

Thyroid Disease

Other _____

Patient History Questionnaire

Highland Retina Associates LLC

Patient Name: _____ Today's Date: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

<u>Surgical</u>: (please list dates of surgeries)

___ **No Surgical History**

Amputation

Angioplasty

Back Surgery

Blood Transfusion

CABG/ Bypass surgery

Defibrillator/ Pacemaker

Gastric Bypass

Heart Stent

Mastectomy

Thyroidectomy

Transplant:

Other_____

Head/ Body Trauma: ***Date:*** _____

Ocular Trauma: ***Date:*** _____

Please list ALL of your current medications, or provide front office with an updated list

Name/dose/frequency/route

_____

_____

_____

_____

_____

_____

_____

_____

Please list your ALLERGIES if any:

_____

_____

_____

<u>FAMILY HISTORY:</u>

Any relative with eye or medical conditions/ if yes please note relationship to patient

DIABETES

CANCER

STROKE / HEART DISEASE

GLAUCOMA

MACULAR DEGENERATION

RETINAL DETACHMENT

CATARACTS

ARTHRITIS/ AUTOIMMUNE DISEASE

KIDNEY DIESEASE

THYROID DISEASE

OTHER

SOCIAL HISTORY:

Marital Status:

Smoking/Tobacco status
Daily Occasional Former Never

Patient History Questionnaire

Highland Retina Associates LLC

Patient Name: _____ Today's Date: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Alcohol status:
Daily Occasional Former Never

Street drugs:
No Yes:_____

Living conditions: □ alone/ □ nursing home/
□ with family or other_____

Do you reside in Skilled Nursing
Facility/Assisted living? Yes No

Do you drive? Yes No

REVIEW OF SYSTEMS: Please circle and explain.

♦ALLERGY/IMMUNOLOGY:

None
Autoimmune
Seasonal / Drug allergies
Recurrent infections

♦CARDIOVASCULAR:

None
Chest Pain
Shortness of Breath
Irregular Heart Beat/ Heart Palpitations
High Blood Pressure
Swelling of Extremities

♦CONSTITUTIONAL:

None
Intolerance to cold/heat
Hair Loss
Nervousness
Fever Chills
Weight Loss Loss of Appetite
Fatigue
Feels Sick/ Weak

♦ENDOCRINE:

None
Excessive Thirst
Excessive Urination
Intolerance of Cold / Heat
Hair Loss
Unstable blood sugar
Sarcoidosis

♦GASTROINTESTINAL:

None
Abdominal Pain
Nausea Vomiting Diarrhea
Bloody Stool
Stomach Ulcer
Trouble Swallowing

♦GENITOURINARY:

None
Urinary problems: _____
Kidney Stones

♦HEMATOLOGY/ONCOLOGY:

None
Easy Bruising

Patient History Questionnaire

Highland Retina Associates LLC

Patient Name: _____ Today's Date: _____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Prolonged Bleeding
Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:

None
Hearing Loss/ Ringing
Sore Throat/ Difficulty Swallowing
Runny Nose/ Congestion/ Nose bleeds
Dry Mouth
Jaw Claudication
Ear Ache
Stiff Neck/ Neck Pain

♦SKIN (INTEGUMENTARY)

None
Rash
Change in Mole
Skin Sores
Nail Changes

♦MUSCULOSKELETAL:

None
Muscle Aches
Joint Pain/ Swelling
Back Pain

♦NERUOLOGIC:

None
Weakness/ Numbness/ Tingling
Headaches
Scalp Tenderness
Dizziness/ Vertigo
Paralysis of Extremities
Tremor
Difficulty walking
Seizures or Convulsions
Fainting

♦PSYCHIATRIC:

None
ADHD
Bipolar Disorder
Depression Anxiety
Panic Attack
Hallucinations/ Schizophrenia

♦RESPIRATORY:

None
Wheezing
Coughing (Productive/ Bloody)
Severe or Frequent Colds
Difficulty Breathing/ Asthma

Please list any other issues you think we may need to know:

_____

_____

THANK YOU. THIS INFORMATION IS CRUCIAL IN THE TREATMENT OF YOUR EYE CONDITION.

ACKNOWLEDGEMENT OF RECEIPT OF NO SHOW POLICY

PATIENT NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE INITIAL) (LAST)

By signing below, I acknowledge that I have received Highland Retina Associates, LLC's No Show Policy

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