Retina Eye Specialists
Raghu C. Murthy, MD, FACS
www.retinaeye.com

1936 Huntington Dr, Suite A, South Pasadena, CA 91030
Tel: (626) 202-2446
Fax: (626) 795-0121

DATE:_____
WHY ARE YOU HERE TODAY?_____
HOW DID YOU FIND US? __DOCTOR __INTERNET __FRIEND/FAMILY __INSURANCE SITE
__HOSPITAL REFERRAL __OTHER
PLEASE SPECIFY:_____

LAST NAME:_____ FIRST NAME:_____ MIDDLE:_____
DATE OF BIRTH:_____ TELEPHONE:_____
MOBILE PHONE:_____ E-MAIL:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
SOCIAL SECURITY NUMBER:_____ DRIVER'S LICENSE:_____

EMPLOYER:_____ OCCUPATION:_____
EMPLOYER'S ADDRESS:_____
WORK TELEPHONE:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____
TELEPHONE:_____ ADDRESS:_____

PRIMARY CARE DOCTOR:_____ CITY:_____ TELEPHONE:_____
OPHTHALMOLOGIST:_____ CITY:_____ TELEPHONE:_____
PHARMACY:_____ STREET:_____ CITY:_____ TELEPHONE:_____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:_____
_____
_____
ALLERGIC TO ANY MEDICATIONS?_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (YES OR NO)
HYPERTENSION (Y / N) HIGH CHOLESTEROL (Y / N) DIABETES (Y / N)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CIRCLE WHICH EYE, LEFT OR RIGHT)
FLOATERS (L / R) FLASHES OF LIGHT (L / R) CURTAIN OVER VISION (L / R)
BLURRY VISION (L / R) DECREASED VISION (L / R) WAVY VISION (L / R)

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Acknowledgement of Financial Responsibility

Insured Patients:

We do accept insurance assignments and will file your insurance company for your visit and any additional testing. However, you are still responsible for all co-payments, co-insurances, deductibles and/or balance as required by your specific insurance plan. You are required to bring you insurance card to each visit. All co-payment and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary co-payments, co-insurance, and deductibles. We will try to obtain pre-approval for treatments and procedures from you insurance company; however, if the insurance company refuses to pay for any reason, you are ultimately responsible for the fees for treatments and procedures.

If your primary insurance does not cover any medications used in the office, you are responsible for payment of medications not covered by the insurance.

Please provide us with your insurance information below.

MEDICAL INSURANCE: __ YES __ NO COMPANY: _____
ARE YOU THE PRIMARY SUBSCRIBER? __ YES __ NO
IF NO, PLEASE WRITE DOWN THE PRIMARY SUBSCRIBERS NAME AND DATE OF BIRTH;
NAME: _____ DATE OF BIRTH: _____

IMPORTANT:
As a courtesy we will submit a claim to your insurance company. If that claim is returned with a charge for a deductible you are responsible to pay that amount in full. The amount varies depending on your insurance policy. There might also be a co-insurance that requires you to pay a certain percentage of the total charges. Your co-insurance amount also varies depending on your insurance policy. Please check with your insurance company to verify the amounts according to your policy.

I understand that I am financially responsible of all charges incurred for services received from **Retina Eye Specialists** whether or not paid by my insurance. If you have a deductible that you have not met, I hereby authorize the doctor and/or his staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Name: _____ **Date:** _____

Signature: _____

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your demographic information, that may identify you and that relates to your past, present or future physical and mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval of a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI without your authorization in these situations: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

My signature below is acknowledgement that the HIPPA Notice of our Privacy Practices has been received, read and understood by me.

Name:_____ **Date:**_____

Signature:_____