Account Number: ________________
Date: ________________

Referring Doctor: ______________________________ Primary Care Doctor: ______________________________

PATIENT INFORMATION					
Patient's Name (First Middle Last)					Nickname
Social Security No.	Date of Birth	Age	Sex (check one) ☐Male ☐Female	Marital Status (check one) ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
Street Address					Email Address
City	State	ZIP code	Home Phone Number ( )	Mobile Phone Number ( )	
Employment: ☐Full Time ☐ Part Time ☐Retired ☐None Student: ☐Full Time Student ☐Part Time Student			Race: ☐White ☐Black/African American ☐Asian ☐American Indian ☐Pacific Islander ☐Other		
Employer/School Name		Employer/School Address			
City	State	ZIP code	Employer Phone Number ( )		

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)					
Name (First Middle Last)					Relationship to Patient
Social Security No.	Date of Birth	Age	Sex (check one) ☐Male ☐Female	Marital Status (check one) ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
Street Address					Email Address
City	State	ZIP code	Home Phone Number ( )	Mobile Phone Number ( )	
Employment: ☐Full Time ☐ Part Time ☐Retired ☐None			Student: ☐Full Time ☐Part Time ☐Not a student		
Employer/School Name		Employer/School Address			
City	State	ZIP code	Employer Phone Number ( )		

INSURANCE INFORMATION	
Please Check One: ☐Patient IS the policy holder ☐Patient IS NOT the policy holder ☐Self Pay	
Primary Insurance Company	Policy Number
Secondary Insurance Company	Policy Number
Check Any That Apply: ☐Residence is a Skilled Nursing Home ☐Insurance is provided through the Veterans Admin.	

By my signature, I certify that the above information is correct to the best of my knowledge:

Patient or Responsible Party **Signature:**____ **Date:**____________________

Account Number: ________________
Date: ________________

MEDICAL HISTORY

Has the patient ever been diagnosed with any MEDICAL PROBLEMS? □ Yes □ No

If yes, please check all that apply:

- □ Arthritis
- □ Asthma
- □ Autoimmune disorder
- □ Lupus
- □ Rheumatoid Arthritis
- □ Cancer (Type________________)
- □ COPD
- □ Emphysema
- □ Diabetes
  - □ Insulin Dependent
  - □ Blood Sugar Range__________
  - □ Last A1C___________
- □ Gastrointestinal disease
  - □ Acid Reflux
  - □ Diverticulitis
  - □ Crohns Disease
  - □ Liver Disease
- □ Heart Disease
  - □ Arrhythmias
  - □ CHF
  - □ Heart Attack
- □ High Blood Pressure
- □ High Cholesterol
- □ Head Injury
- □ HIV
- □ Kidney Disease
- □ Parkinson's
- □ Prostate Disease
- □ Sarcoidosis
- □ Sickle Cell
- □ Stroke
- □ Thyroid disease
- □ Mental Illness
- □ Alzheimer's
- □ Dementia
- □ Depression

List any other medical illnesses:

____

List any PAST SURGERIES or HOSPITALIZATIONS (include dates if known):

____

____

____

Has the patient ever been diagnosed with or treated for EYE PROBLEMS? □ Yes □ No

If yes, please check all that apply:

- □ Amblyopia ("lazy eye")
- □ Cataracts
- □ Dry Eyes
- □ Diabetic Retinopathy
- □ Glaucoma
- □ Macular Degeneration
  - □ Dry □ Wet
- □ Macular Pucker
- □ Myopia (nearsighted)
- □ Ocular Trauma
- □ Retinal Detachment
- □ Retinal Vascular Disease
- □ Strabismus
- □ Uveitis (inflammation)
- □ Other________________

Retina Institute of the Carolinas
&
The Macular Degeneration Center

Account Number: ____________________
Date: ____________________

List any PREVIOUS EYE SURGERY: ____

____

____

Pharmacy Name: ____

Location/Address: ____

List any ALLERGIES: ____

Do you currently take any MEDICATIONS? □ See attached list or □ NONE

Does the patient have a FAMILY HISTORY of any medical or eye problems?

□ Yes □ No

If yes, please check all that apply:

- □ Asthma
- □ Cancer (type________________)
- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ Stroke
- □ Cataract
- □ Blindness
- □ Glaucoma
- □ Macular Degeneration
- □ Retinitis Pigmentosa

Do you SMOKE? □Yes □No □Previously (date quit: ____________________)

Do you DRINK ALCOHOL? □Yes □No □Previously

Do you use RECREATIONAL DRUGS? □Yes □No □Previously

Occupation: ___________________________________

Are you PRESENTLY having any of the following symptoms?

- □ Fever or chills
- □ Difficulty breathing
- □ Chest pain
- □ Kidney trouble
- □ Skin rash
- □ Weight Gain or Loss
- □ GI symptoms
  - □ Acid Reflux
  - □ Diarrhea
  - □ Nausea or Vomiting
- □ Joint Pain
- □ Joint stiffness
- □ Neurologic symptoms
  - □ Headaches
  - □ Seizures
  - □ Numbness
- □ Other__________________

Retina Institute of the Carolinas
&
The Macular Degeneration Center

Account Number: ________________
Date: ________________

Medications

Retina Institute of the Carolinas
&
The Macular Degeneration Center

Account Number: ________________
Date: ________________

Patients or the Responsible Party MUST sign and date all paragraphs below before medical care can be rendered.

<u>Insurance Information</u>

The information regarding my insurance coverage is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Retina Institute of the Carolinas or the insurance company to release any information required to process my claims.

Signature: ____ Date: ________________

<u>Privacy Practices Acknowledgement (HIPAA)</u>

Retina Institute of the Carolinas' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent, and it is always available at the check-in desk. As provided within our Notice, the terms may change, and if so, you may obtain a revised copy by contacting our main office at 803-323-2020.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do agree, we are bound by our agreement.

By signing, you acknowledge that you have read our Notice and consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

Signature: ____ Date: ________________

<u>Release of Medical Information</u>

I authorize the release of medical information to my primary care physician or referring doctor, to consultants if needed, and to the following designees:

1)________________________________ 3)________________________________

2)________________________________ 4)________________________________

Signature: ____ Date: ________________

Account Number: ________________
Date: ________________

Patient Financial Responsibility Agreement

In order for Retina Institute of the Carolinas to continue providing quality medical care to our patients, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our **patient's responsibility.** To this end, we expect our patients to:

Pay all charges not covered by your insurance, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised. If this is not possible, you are expected to **inform our business office before services are rendered.**

Provide us with a copy of your most recent insurance card or other proof of insurance at the time of **each service**. If you do not provide us with this information at **each service**, you agree to **personally pay all unpaid charges.**

Obtain any authorization required under you insurance plan from your primary care physician and/or your insurer prior to each service appointment with us. If you do not receive the required authorization your insurer may not pay us for our services. In these cases, you agree to **personally pay any resulting unpaid charges.**

Monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding their nonpayment and to cooperate with Retina Institute of the Carolinas to resolve the unpaid status of your account. Overpayments will not be returned unless requested by the patient.

By signing this agreement, you agree that Dr. Samiy, Dr. Farr, Dr. Tucker, and the Retina Institute of the Carolinas have the right to be paid for their services, and you acknowledge that unpaid bills older than 90 days from the date of service may be turned over to a debt collection agency or attorney for collection. You agree that you will be responsible for any resulting collection fees, including reasonable attorney fees and/or bank fees incurred as a result of a returned check.

I acknowledge that I have read and understand the Patient Financial Responsibility Agreement and agree to the provisions there-in.

Signature: ____ Date: ________________