

North Texas Retina Consultants

PATIENT INFORMATION FORM

Please print and provide complete information for each item.

First Name: _____ MI: _____ Last Name: _____ Today's Date: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security No.: _____ County: _____

If you have been seen here before, under what name? _____

EMPLOYER INFORMATION:

Employer's Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Telephone: _____ Occupation: _____

RESPONSIBLE PARTY / PARENT / SPOUSE:

Name: _____ Relationship: _____ Occupation: _____

Employer: _____ Social Security Number: _____ Date of Birth: _____

EMERGENCY CONTACT: OTHER THAN SPOUSE:

Name: _____ Relationship: _____ Contact's Address: _____ Telephone: _____

REFERRED BY: _____ **FAMILY PHYSICIAN:** _____

MEDICARE INFORMATION:

Medicare Number: _____ Medicaid Number: _____

INSURANCE INFORMATION:

Insurance Company: _____ Name of Policyholder: _____ Date of Birth: _____

Address: _____ Telephone: _____

Group Number: _____ Policy Number: _____

Policyholder's Employer and Address: _____

SUPPLEMENTAL INSURANCE INFORMATION:

Insurance Company: _____ Name of Policyholder: _____

Address: _____ Telephone: _____

Group Number: _____ Policy Number: _____

Please read and sign below.

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

Signature: X _____ Date: _____

North Texas Retina Consultants

Patient's Full Name

Date

Release Of Information

I hereby authorize North Texas Retina Consultants 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 used in place of the original.

Signature of Patient: _____ **Date:** _____

Or

Signature of Other: _____ **Date:** _____

Responsible Person

Assignment of benefits

I hereby agree to pay the established charges for services and all other charges incurred as a patient of North Texas Retina Consultants.

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

I will cooperate in seeking, collecting, and applying to NTRC, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to NTRC, I agree to collect payment and pay to NTRC within five (5) days of receipt.

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

Signature of Patient: _____ **Date:** _____

Or

Signature of Other: _____ **Date:** _____

Name: _____

Date: _____

Medical and Family History: Please mark (X) the following if they apply to yourself (S) or to your family members (F).

S	F		S	F		S	F	
		Anemia			Emphysema			Kidney Disease
		Arthritis			Gout			Seizures
		Asthma			Heart Attack			Stroke
		Cancer			Hepatitis			Thyroid Disease
		Diabetes (___#yrs)			High Blood Pressure			Vascular Disease

Other Medical Problems (such as): _____ Sexually Transmitted Disease _____ HIV _____
 Hepatitis _____ Tuberculosis _____
 Other _____

Previous Surgery (non-eye surgery): Please give approximate dates _____ no prior surgery

Previous Eye Surgery Please give approximate dates _____ no prior eye surgery

Other Illnesses or Injuries Please give approximate dates _____

Treatments or Hospitalizations: Please give approximate dates _____

Medications (non-eye medications, include non prescription drugs): _____ no medications

Eye Medications _____ no medications

Allergies and Drug Reactions _____ no allergies

Social History: Circle answer

Do you drink alcohol? no yes (if yes, explain) _____

Do you smoke? no yes (if yes, explain) _____

Any use of "street drugs?" no yes (if yes, explain) _____

Do you live alone? no yes

Do you drive? no yes

Name: _____

Date: _____

REVIEW OF SYSTEMS: If you currently have any problems in the following areas, please circle and explain.

Please specify and explain.

SKIN: itching, rash, infection, ulcer, tumors (growths), other none

LYMPH NODES: swelling, tenderness, other none

BONES, JOINTS, MUSCLES: muscles pain/cramps, joint pain/swelling, other none

ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other none

ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity, other none

HEAD: headaches, dizziness, vertigo, other none

EARS: hearing loss, ringing, infections, other none

NOSE: bleeding, loss of smell, congestion, sinus problems, other none

THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other none

NECK: pain, swelling, stiffness, other none

BREAST: tenderness, swelling lumps, discharge, other none

BLOOD: fever/chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other none

RESPIRATORY: wheezing, cough (productive/blood), difficulty breathing, asthma, other none

CARDIOVASCULAR: (heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other none

GASTROINTESTINAL: (stomach/intestine): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other none

GENITOURINARY: (genital/kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other none

NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other none

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other none

This form completed by: Patient Family Staff

History reviewed by _____ M.D. Date _____

NOTICE OF PRIVACY PRACTICES North Texas Retina Consultants

Effective Date: November 1, 2004

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. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Protect Your Patient Health Information

We use health information about you and for treatment to obtain payment and for health care operations, including administrative purposes and evaluation for the quality of care what you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment, and Health Care Options

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For Example: nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment and to pharmacists who are helping with you care.

Payment: We will use and disclose your health information for payment purposes. For example, we may be required to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from you health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reason, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information.

Health Oversight: We may be required to disclose information to assist in the investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Death: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with your confidentiality; for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing you have the right to request that we correct the existing information or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care options.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information to provide the Notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new notice in the waiting area and each exam room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

North Texas Retina Consultants
Patty Smith, Office Administrator
925 Santa Fe Drive
Suite 105
Weatherford, TX 76086
817-594-0914

HIPAA PRIVACY NOTIFICATION

I, _____ have read and understand the HIPPA Privacy Notification of North Texas Retina Consultants.

A copy has been made available to me upon my request.

Signed: _____
Date: _____

If not signed, reason why acknowledgment not obtained:

_____.

Staff witness seeking acknowledgment:

Signed: _____
Dated: _____