SARASOTA RETINA INSTITUTE SRI

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3400 Bee Ridge Rd.
Suite 200
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(941) 921-5335
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Additional Offices:
Lakewood Ranch
Venice

Dear_____:

Welcome to **Sarasota Retina Institute**. This letter will confirm your appointment with **Lissa Rivero, O.D.** on _____ at _____ in our **Sarasota** office.

Please complete the enclosed forms and give them to the front desk receptionist when you arrive for your first appointment. The enclosed patient HIPAA Compliance Notification form also needs to be signed and returned. Bring your insurance cards with you so we may copy them for our record

Plan to spend approximately two hours with us, as a very extensive examination will be performed. Your eyes will be dilated; therefore, we recommend you bring someone who can drive you home. **Please arrive a minimum of 15 minutes before your scheduled appointment.**

Please ask your referring doctor and any other doctors you have seen to send us either a summary or a copy of your records.

You should bring any eye glasses you currently wear, as well as any additional information or hospital records you may have. You may require additional testing during the day, and a complete report of your examination will be sent to your doctor.

FINANCIAL POLICY

We participate with Medicare and several major insurance companies. Payment is due at the time of service, if we do not have a contract with your insurance company or you have a co-pay. Our insurance department will call and verify your insurance and any deductibles and co-pays the day of your first visit. If we provide a service that is considered non-covered by your insurance, payment is due at the time of the service. For your convenience, we accept MasterCard, Visa and Discover and American Express.

ATTENTION MEDICARE PATIENTS: If you have a Medicare Managed Plan, you must let us know the name and phone number of your primary care physician and the name of your managed care plan. We must have authorization from your primary care physician prior to your visit.

ATTENTION MANAGED CARE OR HMO PATIENTS: If you have an insurance plan that requires prior authorization, we must have the name and phone number of your primary care physician. **We must have authorization from your primary care physician prior to your visit. It is your responsibility to obtain this authorization.**

**If your condition is due to an accident, you must notify our insurance department prior to your visit. The phone number is 941-927-2050.

Our staff may call to verify appointments by leaving a message, if necessary. If you miss an appointment, you may be informed by mail to reschedule the appointment.

If you have any questions regarding our financial policy, please contact one of our Patient Account Representatives at 941-927-2050 in our Billing and Insurance office.

Sincerely

Front Office Staff
941-921-5335

SARASOTA RETINA INSTITUTE PATIENT INFORMATION

Please verify that all of the information below is accurate, and make any changes or additions if necessary.

DATE:_____ PATIENT ID:_____REFERRING PHYSICIAN:_____

PATIENT NAME:_____PATIENT'S SOC. SEC. #:_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

DATE OF BIRTH:_____ SEX: _____RACE:_____ETHNICITY: O Hispanic O Not Hispanic

LOCAL PHONE NUMBER:_____CELL PHONE NUMBER:_____

Email Address: _____

EMPLOYER:_____ WORK PHONE NUMBER:_____

YEAR ROUND RESIDENT? YES / NO. IF NO, MONTHS SPENT HERE: FROM_____TO_____

OUT OF STATE ADDRESS:
(STREET) _____

CITY: _____STATE:_____ZIP CODE_____ TELEPHONE NUMBER: _____

SPOUSE/PARENT/GUARDIAN:_____

PERSON RESPONSIBLE FOR
BILL:_____RELATIONSHIP:_____

THE FOLLOWING PERSON IS AUTHORIZED TO DISCUSS MY MEDICAL AND/OR FINANCIAL ISSUES:

NAME:_____PHONE:_____RELATIONSHIP_____

I HAVE REVIEWED ALL INFORMATION AND THE INFORMATION I HAVE PROVIDED IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR ITS INTERMEDIARIES, OR CARRIERS, OR TO THE BILLING AGENT OF THE PHYSICIAN, OR SUPPLIER, ANY INFORMATION NEEDED FOR THIS, OR RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF, OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IN CASE OF PAST DUE PAYMENT, NON-PAYMENT, OR IRREGULAR PARTIAL PAYMENTS, I MAY BE CHARGED COLLECTION AND/OR LEGAL FEES AND/OR ½% INTEREST PER MONTH

PATIENT SIGNATURE: _____ DATE: _____
(OR PARENT OR GUARDIAN, IF MINOR, OR UNDER GUARDIANSHIP)

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME AS APPEARS ON CARD:_____

INSURANCE COMPANY NAME & ADDRESS:_____

PHONE NUMBER:_____POLICY#:_____GROUP #:_____

EFFECTIVE DATE:_____ IS YOUR INSURANCE PLAN AN HMO? YES / NO

PRIMARY CARE PHYSICIAN _____ PHONE #_____

INSURED'S INFORMATION (IF OTHER THAN THE PATIENT)

NAME: _____

SSN#: _____DATE OF BIRTH:_____

SECONDARY INSURANCE

NAME AS APPEARS ON CARD:_____

INSURANCE COMPANY NAME & ADDRESS:_____

PHONE NUMBER:_____POLICY#:_____GROUP #:_____

EFFECTIVE DATE:_____IS YOUR INSURANCE PLAN AN HMO? YES / NO

PRIMARY CARE PHYSICIAN _____ PHONE #_____

INSURED'S INFORMATION (IF OTHER THAN THE PATIENT)

NAME: _____

SSN#: _____DATE OF BIRTH:_____

_____

******IS YOUR CONDITION DUE TO AN AUTO ACCIDENT YES / NO IF YES, WE WILL NEED THE FOLLOWING:

NAME OF AUTO INSURANCE: _____ POLICY #_____ DOA: _____

WORK RELATED ACCIDENT? YES / NO IF YES, WE WILL NEED THE FOLLOWING:

NAME OF EMPLOYER _____ PHONE #_____ DOI: _____

Sarasota Retina Institute

General Health History Form

Name: Mr/Mrs/Miss: _____ (circle one): M/F Date: _____

Date of Birth: _____ Referring Dr: _____

In order to help you better, please fill out the following information

Cardiovascular	Yes/No
Do you have any heart problems?	Yes/No
Do any of the following apply?	Yes/No
Arrythmia	Yes/No
Irregular Heart Beat	Yes/No
Coronary Artery Disease	Yes/No
Pace Maker	Yes/No
High Blood Pressure	Yes/No
Elevated Cholesterol	Yes/No

Pulmonary	Yes/No
Asthma	Yes/No
Bronchitis	Yes/No
Emphysema	Yes/No
Shortness of Breath	Yes/No
COPD	Yes/No
Sleep Apnea	Yes/No
CPAP use?	Yes/No

Gastrointestinal Tract	Yes/No
Do you have any GI problems?	Yes/No
Hernia	Yes/No
Stomach Problems	Yes/No
Ulcers	Yes/No

Blood	Yes/No
Are you anemic?	Yes/No
Do you have bleeding problems?	Yes/No
Are you on a blood thinner?	Yes/No
HIV	Yes/No

Skeletal	Yes/No
Amputations/lost appendages	Yes/No
Arthritis/Rheumatoid/Osteoarthritis	Yes/No
Osteoporosis	Yes/No

Neurological	Yes/No
Facial Palsy (which side)? L/R	Yes/No
Bells Palsy/Ramsay Hunt/other	Yes/No
Memory Issues/Dementia/Alzheimers	Yes/No
Headaches	Yes/No
Migraines	Yes/No
Paralysis	Yes/No
Parkinsons	Yes/No
Parkinsonism	Yes/No
Multiple Sclerosis	Yes/No
Seizures	Yes/No

Endocrine	Yes/No
Diabetes	Yes/No
Type 1/Type 2 (please circle)	
Insulin	Yes/No
Thyroid Issues	Yes/No
Hypo/Hyper (please circle)	
Hepatitis	Yes/No

Urinary Tract	Yes/No
Kidney Problems	Yes/No
Prostate Problems	Yes/No

Cancer	Yes/No
Have you been diagnosed with cancer?	Yes/No
If yes, list type, date, and treatment	_____

Other	Yes/No
Anxiety	Yes/No
Depression	Yes/No
Hard of Hearing	Yes/No
Sinus Issues	Yes/No
Shingles/Skin Rash/Other	Yes/No
Weight Loss/Gain (please circle)	Yes/No

Is There Any Other Diagnosis Not Listed?
Please List Below

_____ _____ _____

_____ _____ _____

Sarasota Retina Institute

Ocular Health History Form

Name: _____ Date: _____

What is your **PRIMARY** complaint about your **eyes** today? _____

_____

Any other eye complaints? _____

_____

When and where was your last eye exam? _____

Have you ever been diagnosed for any of the following: (**please check**)

	Yes/No
Cataracts	Yes/No
Cornea Problems	Yes/No
Double Vision	Yes/No
Eye Trauma	Yes/No
Glaucoma	Yes/No
Graves Disease	Yes/No
Macular Degeneration	Yes/No
Retinal Detachment/Tear	Yes/No
Temporal Arteritis	Yes/No
Other (please list)	Yes/No

Family History

please list family member diagnosed

Double Vision	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Detachment	_____
Retinal Tear	_____
Temporal Arteritis	_____
Graves Disease	_____
Diabetes	_____

List any eye surgery and / or laser eye surgeries that you have had:

EYE SURGERY	**Right/Left**	**Physician/Location/Year**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any medications or vitamins for your eyes? If so, please list below.

EYE MEDICATIONS	**Right/Left**	**How Many Times Per Day?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name _____ Date _____

List **ALL** medications that you currently take in the sections below:

Do you take any prescription medications? YES NO OTHER MEDICATIONS	**Strength** (mg, tablet, drop etc.)	**Directions** (times per day or week, as needed, etc)	**Medication is taken** (oral, injection, topical, etc.)

Do you take any OTC medications? YES NO OVER THE COUNTER MEDICATIONS (herbals, vitamins, etc.)	**Strength** (mg, tablet, drop etc.)	**Directions** (times per day or week, as needed, etc)	**Medication is taken** (oral, injection, topical, etc.)

Please list any allergies to medications: _____

_____

_____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: _____ **Concerns:** ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Retired

Tobacco use: ☐ Never ☐ Quit (when) _____ ☐ Current smoker: Packs/day, how many years _____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often _____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often _____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

Describe: _____

SARASOTA RETINA INSTITUTE

HIPAA COMPLIANCE NOTIFICATION TO PATIENTS

To Our Valued Patients:
The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent of disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future, you may refuse all or part of disclosure of your personal health information. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the governmental rules, laws and regulations. We want to ensure that our office never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem, so we may remedy the situation promptly.

If you have any questions, please ask to speak to the Privacy Officer, Lois Delagrange.

Thank you for being one of our highly valued patients.

_____ _____

Signature of Patient or Authorized Patient Date