



SARASOTA RETINA
INSTITUTE

SRI

3400 Bee Ridge Rd.
Suite 200
Sarasota, FL 34239
(941) 921-5335
Fax (941) 921-1741

Additional Offices:
Lakewood Ranch
Venice

Melvin C. Chen, M.D., F.A.C.S.
Marc H. Levy, M.D., F.A.C.S.
Jody G. Abrams, M.D., F.A.C.S.
Alexander J. Schneider, M.D.
Thomas C. Spoor, M.D., F.A.C.S.
Lissa V. Rivero, O.D., F.A.A.O.

Dear: _____

Welcome to **Sarasota Retina Institute**. This letter will confirm your appointment with **Alexander J. Schneider, M.D.** on _____ at _____ in our _____ 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 records.

Your appointment may take 1 to 2 hours, depending on your medical situation. Please arrive a minimum of 15 minutes before your scheduled appointment.

You should bring any eye glasses you currently wear, and since your eyes may be dilated, we recommend that you bring someone who can drive you home.

Since a limited number of patients are scheduled, please notify us if you are unable to keep this appointment. With early notification we can offer the appointment to another patient. If you have any questions, please call us. **We are here to serve you.**

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: ☐ Hispanic ☐ 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 1/2% 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 Do you have any heart problems? Do any of the following apply? Arrythmia Irregular Heart Beat Coronary Artery Disease Pace Maker High Blood Pressure Elevated Cholesterol	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No	Neurological Facial Palsy (which side)? L/R Bells Palsy/Ramsay Hunt/other Memory Issues/Dementia/Alzheimers Headaches Migraines Paralysis Parkinsons Parkinsonism Multiple Sclerosis Seizures	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
Pulmonary Asthma Bronchitis Emphysema Shortness of Breath COPD Sleep Apnea CPAP use?	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No	Endocrine Diabetes Type 1/Type 2 (please circle) Insulin Thyroid Issues Hypo/Hyper (please circle) Hepatitis	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
Gastrointestinal Tract Do you have any GI problems? Hernia Stomach Problems Ulcers	Yes/No Yes/No Yes/No Yes/No Yes/No	Urinary Tract Kidney Problems Prostate Problems	Yes/No Yes/No Yes/No
Blood Are you anemic? Do you have bleeding problems? Are you on a blood thinner? HIV	Yes/No Yes/No Yes/No Yes/No Yes/No	Cancer Have you been diagnosed with cancer? If yes, list type, date, and treatment	Yes/No Yes/No _____
Skeletal Amputations/lost appendages Arthritis/Rheumatoid/Osteoarthritis Osteoporosis	Yes/No Yes/No Yes/No Yes/No	Other Anxiety Depression Hard of Hearing Sinus Issues Shingles/Skin Rash/Other Weight Loss/Gain (please circle)	Yes/No Yes/No Yes/No Yes/No Yes/No 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	Family History	
		please list family member diagnosed	
Cataracts	Yes/No	Double Vision	_____
Cornea Problems	Yes/No	Glaucoma	_____
Double Vision	Yes/No	Lazy Eye	_____
Eye Trauma	Yes/No	Macular Degeneration	_____
Glaucoma	Yes/No	Retinal Detachment	_____
Graves Disease	Yes/No	Retinal Tear	_____
Macular Degeneration	Yes/No	Temporal Arteritis	_____
Retinal Detachment/Tear	Yes/No	Graves Disease	_____
Temporal Arteritis	Yes/No	Diabetes	_____
Other (please list)	Yes/No		

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 Delagrangue.

Thank you for being one of our highly valued patients.

Signature of Patient or Authorized Patient

Date