SARASOTA RETINA INSTITUTE SRI

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Usma P. Chatha, D.O.
Thomas C. Spoor, M.D., F.A.C.S.
Lissa V. Rivero, O.D., F.A.A.O.

Additional Offices:
Lakewood Ranch
Venice

Dear _____:

Welcome to **Sarasota Retina Institute.** This letter will confirm your appointment with **Usma P. Chatha, D.O.** 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 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 to four 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. If you have had skull x-rays, CT scans, arteriograms, or MRI's in the past three years, please bring the films with you, not just the report. Do not mail them as they can be lost or delayed. Likewise, if you have a problem with either unequal pupils, deviation of the eyes, or drooping eyelids, please bring old photographs with you. The pictures can be baby, family, wedding or ID photos.

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, 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

HIPAA COMPLIANCE NOTIFICATION TO PATIENTS

To Our Valued Patients:

The misuse of protected health information (PHI) 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 went 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. Moreso, 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

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 SOC. SEC. #**	
STREET ADDRESS:			
CITY:	**STATE:**	**ZIP:**	
BIRTHDATE:	**GENDER:**	**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 STREET ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**TELEPHONE #**
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)

SARASOTA RETINA INSTITUTE

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME AS APPEARS ON CARD:		
INSURANCE COMPANY NAME & ADDRESS		
PHONE #	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:		
SOC. SEC. NUMBER:	DATE OF BIRTH:	

SECONDARY INSURANCE

NAME AS APPEARS ON CARD:		
INSURANCE COMPANY NAME & ADDRESS		
PHONE #	POLICY #	GROUP #
PRIMARY CARE PHYSICIAN:		PHONE #
INSURED'S INFORMATION (If other than the patient)		
NAME:		
SOC. SEC. NUMBER:	DATE OF BIRTH:	

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT?	YES ☐ NO ☐
IF YES, WE WILL NEED THE FOLLOWING INFORMATION:	
NAME OF AUTO INSURANCE:	Policy #
DATE OF ACCIDENT:	
IS YOUR CONDITION DUE TO A WORK RELATED INCIDENT?	YES ☐ NO ☐
IF YES, WE WILL NEED THE FOLLOWING INFORMATION:	
NAME OF EMPLOYER:	Employer Phone #
DATE OF INCIDENT:	

SARASOTA RETINA INSTITUTE

General Health History Form

NAME:	GENDER:	HEIGHT:	WEIGHT:	DATE:

DATE OF BIRTH:	PRIMARY PHYSICAN:	REFERRING PHYSICIAN:

PLEASE ANSWER THE FOLLOWING:

CARDIOVASCULAR			NEUROLOGICAL		
Heart problems?	YES	NO	Facial Palsy?	YES	NO
Arrythmia?	YES	NO	If yes, which side?	L	R
Irregular Heart Beat?	YES	NO	Any Bell's Palsy / Ramsay Hunt / Other (circle)	YES	NO
Coronary Artery Disease?	YES	NO	Memory Issues / Dementia / Alzheimers (circle)	YES	NO
Pacemaker?	YES	NO	Headaches?	YES	NO
High Blood Pressure?	YES	NO	Migraines?	YES	NO
Elevated Cholesterol?	YES	NO	Paralysis?	YES	NO
PULMONARY			Parkinson's Disease?	YES	NO
Asthma?	YES	NO	Multiple Sclerosis?	YES	NO
Bronchitis?	YES	NO	Seizures?	YES	NO
Emphysema?	YES	NO	**ENDOCRINE**		
Shortness of Breath?	YES	NO	Diabetes Mellitus? Type 1 or Type 2 (circle)	YES	NO
COPD?	YES	NO	On insulin?	YES	NO
Sleep Apnea?	YES	NO	Thyroid Problems? Hypo or Hyper (circle)	YES	NO
If yes to sleep apnea, any CPAP or BiPAP use? (circle which)			Hepatitis? A / B / C (circle)	YES	NO
GASTROINTESTINAL			**UROLOGICAL**		
Hernia?	YES	NO	Kidney issues?	YES	NO
Stomach issues?	YES	NO	Prostate issues?	YES	NO
Ulcers?	YES	NO	**CANCER**		
Other GI problems?	YES	NO	Have you ever been diagnosed with cancer?	YES	NO
BLOOD			If yes, what type of cancer?		
Are you anemic?	YES	NO	List date and type of treatment:		
Any bleeding problems?	YES	NO	**OTHER HEALTH ISSUES**		
Are you on any blood thinners?	YES	NO	Anxiety?	YES	NO
HIV diagnosis?	YES	NO	Depression?	YES	NO
Autoimmune?	YES	NO	Hearing Loss?	YES	NO
MUSCULOSKELETAL			Sinus Issues?	YES	NO
Any amputations or loss of appendages?	YES	NO	Shingles / Skin Rashes / Other? (circle)	YES	NO
Gout?	YES	NO	Recent Weight Loss or Weight Gain? (circle)	YES	NO
Osteoarthritis?	YES	NO	Please list any other health issues		
Osteoporosis?	YES	NO			
Rheumatoid Arthritis?	YES	NO			

SARASOTA RETINA INSTITUTE - General Health History Form (Continued)

PATIENT NAME:

If you need more lines for any sections, please continue on back side of page.

PREVIOUS GENERAL SURGERIES / List surgeries and year of surgery	

PRESCRIPTION MEDICATIONS					
Name of Medication			**Dose** (20 mg, etc)	**How often used?** (once a day, as needed, etc)	**How taken?** (oral, topical, injection)
Currently on *PREDNISONE*?	**Yes**	**No**			

OVER-THE-COUNTER SUPPLEMENTS (including vitamins and pain relievers)	

ALLERGIES:	

SOCIAL HISTORY					
Marital status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Life Partner
Do you live in Florida year-round? ☐ Yes ☐ No (If no, list other location)					
Occupation Current:		**Occupation Past:**			☐ Retired
Tobacco Use	☐ Never Smoked				
	☐ Quit (when?)				
	☐ Smoker – Indicate below which you use / How much you use / How long you've used				
	☐ Cigarettes	How many a day?	How many years?		
	☐ Cigars	How many a day?	How many years?		
	☐ Chewing Tobacco	How often?	How many years?		
	☐ Vape	How much a 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/Recreational Drug Use (including marijuana, cocaine, steroids, etc) ☐ Never ☐ Past ☐ Current Describe type of drug use and how often:					

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Ocular Health History Form

PATIENT NAME:

If you need more lines for any sections, please continue on back side of page.

What is your **PRIMARY** complaint about your **eyes** today?
Any other eye complaints?
When and where was your last eye examination?

Have you ever been diagnosed with any of the following: (Please Check)					
Cataracts	☐ YES	☐ NO		**FAMILY HISTORY**	
Cornea Problems	☐ YES	☐ NO		*Please List Family Members Diagnosed With Below*	
Double Vision	☐ YES	☐ NO		Double Vision	
Eye Trauma	☐ YES	☐ NO		Glaucoma	
Glaucoma	☐ YES	☐ NO		Lazy Eye	
Graves Disease	☐ YES	☐ NO		Macular Degeneration	
Macular Degeneration	☐ YES	☐ NO		Retinal Detachment/Tear	
Retinal Detachment / Tear	☐ YES	☐ NO		Temporal Arteritis	
Temporal Arteritis	☐ YES	☐ NO		Graves Disease	
Other (please list)	☐ YES	☐ NO		Diabetes	

List any eye surgeries and / or laser eye procedures that you have had in the past:				
EYE SURGERY	Right or Left	Physician	Location	Year

Do you take any eye medications (including eye vitamins) or use eye drops? If so, please list below:		
Eye Medication	Right Eye / Left Eye / Both Eyes	How many times a day?