SARASOTA RETINA INSTITUTE SRI

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Additional Offices:
Lakewood Ranch
Venice

Dear _____:

Welcome to **Sarasota Retina Institute.** This letter will confirm your appointment with **Melvin C. Chen, 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 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.

**Your appointment may take 1 to 2 hours,** depending on you 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 with you 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 at (941) 921-5335.

**We appreciate you choosing SARASOTA RETINA INSTITUTE to help manage your eye care.**

## 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: | | | | | |

**SARASOTA RETINA INSTITUTE**

**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? |
| | | |
| | | |
| | | |