MID-SOUTH RETINA ASSOCIATES, LLC

MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

Patient Name: _____ Age: ____ Occupation: _____ Date:_____

Referring Physician: _____ Primary Care Doctor: _____

PAST MEDICAL HISTORY: (Circle)

Diabetes : type 1 type 2	High Blood Pressure	Heart Failure	Thyroid Disorder	Tuberculosis	Arthritis
Duration :_____	Heart Attack	Emphysema	AIDS/HIV	Lupus	Cancer
A_1C: _____	Stroke	Asthma	Leukemia	Lymphoma	Sarcoid
Last Glucose:_____					

LIST ANY MAJOR ILLNESSES: _____

List All Medications Currently Using: ☐ **List Provided and Attached**

Medicine	Dose	Times Per Day
1._____		1 2 3 4
2._____		1 2 3 4
3._____		1 2 3 4
4._____		1 2 3 4
5._____		1 2 3 4
6._____		1 2 3 4
7._____		1 2 3 4
8._____		1 2 3 4
9._____		1 2 3 4
10._____		1 2 3 4
11._____		1 2 3 4
12._____		1 2 3 4

Drug Allergies: (Circle)

Latex	Sulfa
Penicillin	Tetracycline
Aspirin	Cipro
Contrast Dye	Iodine

Other Allergies: _____

_____

_____

_____

Circle any of the surgical procedures patient has had and list any additional surgeries not circled in space provided.

Tonsillectomy	Hysterectomy (removal uterus/ovaries)
Prostate Surgery	Heart Bypass
Gall Bladder Removal	Lumbar Discectomy (back surgery)

Anesthetic Complications: Yes No

Cataract Surgery: Right Left

Retina Reattachment: Right Left

Other Surgeries:_____

_____

_____

Hospitalizations:_____

For:_____

Eyes:	**Yes**	**No**	**Right**	**Left**
Loss of Vision	☐	☐	☐	☐
Loss of Vision (<5 minutes)	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐
Distorted Vision (straight lines crooked)	☐	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	☐
Previous Eye Disease or Treatment:_____	☐	☐		

	Yes	**No**	**Right**	**Left**
Floaters	☐	☐	☐	☐
Flashes of Light	☐	☐	☐	☐
Loss of Side Vision	☐	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐	☐
Double Vision				
Burning	☐	☐	☐	☐
Lazy Eye/Amblyopia	☐	☐	☐	☐

Does visual problem affect daily activities? (Explain)_____

MID-SOUTH RETINA ASSOCIATES, LLC

MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

REVIEW OF RECENT HEALTH (SYSTEMS)

Constitutional Symptoms	**Yes**	**No**
Fever/Chills	☐	☐
Weight Loss	☐	☐
Fatigue	☐	☐
Night Sweats	☐	☐

Rheumatology	**Yes**	**No**
Lyme Disease	☐	☐
Other	☐	☐

Describe:_____

_____

Ear, Nose, Throat, Mouth	**Yes**	**No**
Sinus Congestion	☐	☐
Sore Throat	☐	☐
Runny Nose	☐	☐
Cold Sore Lip/Mouth	☐	☐
Cardiovascular	☐	☐
Chest Pain (Angina)	☐	☐
Rapid Heartbeat	☐	☐
Heart Skips Beat	☐	☐
Short of Breath Walking	☐	☐
Enlarged Heart	☐	☐
Respiratory (Breathing/Lungs)	☐	☐
Cough	☐	☐
Difficulty Breathing	☐	☐
Asthma Attacks	☐	☐
Allergy	☐	☐
Seasonal Allergies	☐	☐
GU (Kidney/Bladder/Genitals)	☐	☐
Blood in Urine	☐	☐
Burns to Urinate	☐	☐
Sores on Genitals	☐	☐
Kidney Stones	☐	☐
Renal Failure	☐	☐
Dialysis	☐	☐

GI (Stomach/Intestines)	**Yes**	**No**
Diarrhea	☐	☐
Constipation	☐	☐
Blood in BM	☐	☐
Cramps/Pain	☐	☐
Skin	☐	☐
Tick Bites	☐	☐
Rashes	☐	☐
Reproductive	☐	☐
Pregnant	☐	☐
Last Menstrual Period	_____	
Neuro	☐	☐
Loss of Balance	☐	☐
Headaches	☐	☐
Weakness Arm/Leg	☐	☐
CVA/Stroke	☐	☐
Numbness of Arm/Leg	☐	☐
Seizure Disorder	☐	☐
Hematologic (Blood/Lymph)	☐	☐
Anemia (Low Blood Count)	☐	☐
Abnormal White Blood Cells	☐	☐
Swollen Lymph Nodes	☐	☐
Bleeding Disorder	☐	☐
Sickle Cell Disorder	☐	☐

FAMILY HISTORY	**Yes**	**No**	**Relationship to Patient**
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Attacks	☐	☐	_____
High Blood Pressure	☐	☐	_____
Tuberculosis	☐	☐	_____
Stroke	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Married **Yes**_____ **No**_____

Do you use drugs for pleasure? **Yes**_____**No**_____

SMOKING STATUS (Circle)

Current smoker Chewing nicotine product

Former smoker Previous history of Chewing tobacco

Never smoked Using nasal snuff

Current every day smoker

Current some day smoker

Attempting to quit using chewing tobacco

Recently quit using chewing tobacco

Patient Signature:_____ **Date:** _____

_____**(For office use below)**_____

Physician Signature:_____ Date: _____

Tech Update: Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____

Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____

MID-SOUTH RETINA ASSOCIATES, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/Personal Representative Date:

_____

Printed Name of Patient/Personal Representative

If Personal Representative, relationship to Patient: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

MID-SOUTH RETINA ASSOCIATES, LLC

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.

Effective as of April 14, 2003, Revised May 13, 2015

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. "Protected health information, is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services. We are required to abide by the items of our Notice of Privacy Practices ('Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request, and place the revised Notice on our website.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as with a pharmacy when calling in your prescription.

Payment. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit. We will obtain your authorization before using your information for marketing purposes.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You Can Object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you, only your PHI that is directly relevant to that person's involvement in your health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care, only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes.

Notwithstanding your objection, we are still permitted to share your PHI as necessary for emergency circumstances.

Required Uses or Disclosures. We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with applicable laws.

Our Contact with You. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you. We will contact you for permission to use or disclose your information for reasons not described in this Notice of Privacy Practices. We will notify you in the event you are affected by an unsecured breach of information.

Business Associates. We may use and disclose your PHI with other business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

Other Uses and Disclosures. We may use or disclose your PHI when such use or disclosure is: required by law or used for law

enforcement purposes; necessary for public health activities; necessary to report abuse, neglect or domestic violence; for health oversight activities; for judicial and administration proceedings; for medical research; to coroners, medical examiners or funeral directors; for cadaveric organ, eye or tissue donation purposes; to avert a serious threat to the health or safety of a person or the public; for specialized governmental functions; or for workers compensation.

Remuneration. We may not receive compensation or remuneration in exchange for the release of your protected health information unless a valid authorization to such extent has been obtained from you or such release is allowed by applicable law.

ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION.

You may authorize us to use or disclose your PHI for other purposes. You may revoke your authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we received your revocation.

YOUR PATIENT RIGHTS.

Restrictions. You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law.

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments. You must make such requests in writing. We will accommodate reasonable requests, but may condition such accommodations upon our receipt of a satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact.

Restricted Disclosures to Health Plans. If you have paid for services "out of pocket" and in full, we will accommodate your request not to disclose PHI related solely to those services to a health plan, unless we must disclose the information for treatment or as required by law.

Access. You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing, and we will charge you reasonable cost-based fees for expenses (such as copying and postage). Instead of paper copies, if the information is maintained in an electronic health record, you may request that the information be provided in electronic form to either you or to a designated third-party if such designation is clear, conspicuous, and specific. You may be charged a reasonable cost-based fee for the electronic copy, which shall not exceed our labor costs in responding to the request. Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed.

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement.

Accounting. You have the right to receive a listing of disclosures of your PHI. With respect to information contained in paper form, the accounting will include the disclosures made for purposes other than treatment, payment, health care operations, to you upon your request, your authorization, to individuals involved in your care or as allowed by law. With respect to information contained in an electronic health record, the accounting will contain the disclosures made for purposes other than to you upon your request, your authorization, or as allowed by applicable law. You may request all such disclosures made during the last 6 years (but not any disclosures made prior to April 14, 2003) for information stored in paper form and made during the last 3 years (but not any disclosures made prior to implementation of the electronic health records system) for information stored in an electronic health record. If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with your additional request.

Electronic Notice. If you received this notice by email or off our web-site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

QUESTIONS AND COMPLAINTS.

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer at 6005 Park Avenue, Suite 624B, Memphis, TN 38119 or by calling 901 682-1100.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate in any way against you if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

MID-SOUTH RETINA ASSOCIATES, LLC

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of Mid-South Retina Associates, LLC has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Mid-South Retina Associates, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ **Date:** _____

MID-SOUTH RETINA ASSOCIATES, LLC

PATIENT INFORMATION FORM

E-mail: _____ Today's Date: _____

Patient's name _____
Last First Middle

Address: _____ Home telephone: _____

City, state, zip _____ Cell phone #: _____

Date of birth: _____ Sex: _____ Race: _____ Social Security #: _____

Marital status: ❑ Single ❑ Married ❑ Divorced: ❑ Widowed: Ethnicity: _____

Employer: _____ Work telephone: _____

Occupation: _____ Retired: ❑ Yes ❑ No Disabled: ❑ Yes ❑ No

If retired, name of company retired from: _____ Retirement date: _____

Doctor who referred you to us: _____

If not physician referred, how did you hear of our practice ❑ Friend ❑ Internet ❑ Other _____

Medical Doctor/Diabetic doctor: _____ Preferred Language: _____

Pharmacy Name: _____ Telephone #: _____

Spouse's Name: _____ Date of Birth: _____

Social Security #: _____ Spouse Cell Phone #: _____

Employer: _____ Work Telephone #: _____

Person to Contact in Case of Emergency (Not Living With you):

Name: _____ Telephone #: _____
Relationship

BILLING INFORMATION

Primary Insurance

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

RELATIONSHIP TO POLICY HOLDER: _____

Secondary Insurance

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

RELATIONSHIP TO POLICY HOLDER: _____

Work Comp / Voc Rehab / Other?

Eye Injury? _____ Which Eye? _____ Date of Injury: _____

PLEASE SIGN RELEASE OF INFORMATION AUTHORIZATION ON BACK OF THIS FORM

Registered by: _____ Account #: _____ Date: _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Person Responsible For Bill: _____

Father's Name: _____ Social Security #: _____

Address: _____ Home Telephone: _____

Employer: _____ Date of Birth: _____

Occupation: _____ Work Telephone #: _____

Mother's Name _____ Social Security #: _____

Address: _____ Home Telephone: _____

Employer: _____ Date of Birth: _____

Occupation: _____ Work Telephone #: _____

EXPLANATION OF COLLECTION AND CHARGES
(A LIST OF CHARGES WILL BE FURNISHED UPON REQUEST)

PAYMENT POLICY

PAYMENT ARRANGEMENTS MUST BE MADE AT THE TIME SERVICE IS RENDERED. I UNDERSTAND THAT MID-SOUTH RETINA ASSOCIATES, LLC ("THE PRACTICE"), MAY ASSIST WITH FILING OF INSURANCE FORMS, BUT I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

AGREEMENT TO PAY

Assignment of Benefits and Guarantee of Account: In consideration of all services and supplies provided by Mid-South Retina Associates, LLC, I understand and agree that I have full responsibility to pay Mid-South Retina Associates, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Mid-South Retina Associates, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Mid-South Retina Associates, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I agree, in order for Mid-South Retina Associates, LLC to coordinate my care, service my account or to collect monies I may owe, Mid-South Retina Associates, LLC and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Mid-South Retina Associates, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from the above authorizations and agreements.

APPOINTMENT REMINDER POLICY

I authorize this Practice and their agent to place appointment reminder phone calls to the phone number I have listed on my patient form.

CONSENT TO TREATMENT

I authorize the physicians of the Practice, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and have-been advised not to drive. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: _____ Date: _____

_____ _____

_____ _____