Retina Research Center, PLLC

9707 Anderson Mill Road, Suite 100
Austin, TX 78750

Office (512) 279-1251
Fax (512) 600-2882

PATIENT HEALTH QUESTIONNAIRE

Patient Name: ________________________________ Today's Date: ____________

PHYSICIAN INFORMATION

Family Doctor (PCP):____

Name of ophthalmologist/optometrist:_____________________________________

Other doctors:____

____

ALLERGIES

Do you have any serious allergies to any medications: ❑ Yes ❑ No

If yes, please list medication:____

Do you have any allergies to latex or adhesives? ❑ Yes ❑ No

WHAT IS THE REASON FOR YOUR VISIT TODAY (CHECK ALL THAT APPLY)

❑ Blind spot	❑ Distorted vision	❑ Loss of vision
❑ Blurred vision	❑ Eye pain	❑ Night vision loss
❑ Diabetic eye exam	❑ Flashes of light	❑ Trauma
❑ Difficulty reading	❑ Floaters	❑ Other

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SOCIAL HISTORY

Marital Status: ❑Married/Partner ❑ Single ❑ Divorced ❑ Widowed ❑ Decline to answer

Do you drive a car: ❑ Yes ❑ No

If so, do you have restrictions: ❑ Local only ❑ Daytime only

Do you currently use tobacco products? ❑ Yes ❑ No

If yes, how much? ____

Have you ever used tobacco products? ❑ Yes ❑ No

If yes, when did you quit? ____

Do you drink alcohol? ❑ Yes ❑ No

If yes, how much? ____

Occupation: ____

❑ Full-time ❑ Part-time ❑ Retired ❑ Not employed

SURGICAL HISTORY

Please list all surgeries you have had: ❑ None

____

____

President/Investigator – Brian B. Berger, MD
Investigators: Fuad Makkouk, MD, Stephen B. Whiteside, MD, Byron David Brent, MD
Research Director – Ivana Gunderson, BS
Coordinators/BCVA –Ivana Gunderson, Daniela Wilson, Valerie Gatavaski, Kaitlyn Timmons, Daniela Vega Pereira
Imagers – Yong Ren

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MEDICAL HISTORY	OCULAR HISTORY

	SELF	FAMILY		SELF	FAMILY
HIGH BLOOD PRESSURE	YES/NO	YES/NO	**CATARACTS**	YES/NO	YES/NO
HEART DISEASE	YES/NO	YES/NO	**GLAUCOMA**	YES/NO	YES/NO
DIABETES (YEAR OF DIAGNOSIS:_____)	YES/NO	YES/NO	**RETINAL DETACHMENT**	YES/NO	YES/NO
CANCER	YES/NO	YES/NO	**EYE INJURY**	YES/NO	YES/NO
ARTHRITIS	YES/NO	YES/NO	**DIABETIC RETINOPATHY**	YES/NO	YES/NO
ASTHMA	YES/NO	YES/NO	**MACULAR DEGENERATION**	YES/NO	YES/NO
STROKE	YES/NO	YES/NO	**EYE SURGERY**	YES/NO	YES/NO
AUTOIMMUNE DISEASE	YES/NO				
HIV	YES/NO				
HEPATITIS	YES/NO				
KIDNEY DISEASE	YES/NO				
NEUROPATHY	YES/NO				

MEDICATIONS

Please list all medications/vitamins and supplements CURRENTLY taking ❑ None

NAME OF MEDICATION	DOSAGE

Acknowledgement of Review of Notice of Privacy Practices

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NOTICE OF PRIVACY PRACTICES 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.

This practice uses and discloses health information about you for treatment, payment of treatment, administrative purposes, and for evaluation of quality of care you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact our Site Director.

TREATMENT: We are permitted to use and disclose your medical information to bill and collect payment for treatment. We may complete a claim for to obtain payment from your insurer. The form will contain medical information, such as your diagnosis and service provided to you, that your insurer needs to approve payment to us.

HEALTHCARE OPERATIONS: We are permitted to use or disclose your medical information for the purpose of health care operations, which are activities that support this practice and ensure the quality of care. For example, we may ask another physician to review this practices' charts and medical records to evaluate our performance, so that we can improve our quality of care..

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION: There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or opportunity to object. In other situations we will ask for your written authorizations before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke the authorizations, in writing, to stop further uses and disclosures. However, any revocation will not apply to disclosures to uses already made or taken in reliance on that authorization.

PUBLIC HEALTH ABUSE OR NEGLECT AND HEALTH OVERSIGHT: We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births or deaths), or injury to a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report abuse or neglect of elders or the disabled. We may disclose your medical information to a health oversight agency for those activities authorized by law, such as audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor health care and compliance with other laws, such as civil rights laws.

LEGAL PROCEEDINGS AND LAW ENFORCEMENT: We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the

court or other appropriate legal process, if certain requirements are met. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided the information is released pursuant to legal process, such as a warrant or subpoena; pertains to victim of crime and you are incapacitated: pertains to a person who has died under circumstances that may be relevant to criminal conduct; is about a victim of crime and we are unable to obtain the person's agreement; is released because of a crime that has occurred on these premises: or is released to locate a fugitive, missing person, or suspect. We may release information if we believe it will prevent a threat to the health or safety of a person.

WORKER'S COMPENSATION: We may disclose your medical information as required by Texas Worker's Compensation law.

INMATES: If you are an inmate or under custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your healthy or the health and safety of others, or for the safety and security of the institution.

MILITARY, NATIONAL, SECURITY AND INTELLIGENCE ACTIVITIES, PROTECTION OF THE PRESIDENT: We may disclose your medical information for specialized government functions such as separation or discharge from the military service, request as necessary by appropriate military command officer (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provisior of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

RESEARCH ORGAN DONATION, CORONERS MEDICAL EXAMINERS AND FUNERAL DIRECTORS: When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation, if you are a medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

REQUIRED BY LAW: We may release your medical information where the disclosure is required by law.

YOUR RIGHTS UNDER FEDERAL PRIVACY REGULATIONS: The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPPA). Those regulations create several privileges that patient may exercise. We will not retaliate against a patient exercising those rights.

REQUESTED RESTRICTIONS: You may request that we restrict on how your previous health information is used or disclosed for treatment, payment, or healthcare operations. We DO NOT

have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of

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information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the Privacy Officer. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

RECEIVING CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS: You may request that we send communication of protected health information by alternative means or to an alternative location. This request must be made in writing to the Privacy Officer. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

INSPECTION AND COPIES OF PROTECTED HEALTH INFORMATION: You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of our health information also be made in writing. Please send your request to the Privacy Officer. We can refuse to provide some of the information you ask to inspect or ask to be copied, if the information includes psychotherapy notes, includes the identity of a person who provided information if it was obtained under a promise of confidentiality, us a subject to the Clinical Laboratory Improvements Amendments of 1988, or was completed in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform your of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee The Texas Sate Board of Medical Examiners has set limits on fees for copies of medical records.

AMENDMENT OF MEDICAL INFORMATION: You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the Privacy Officer. We will respond within 60 days of your request. We may refuse to allow an amendment if the information (a) wasn't created by this practice, (b) is not part of the Designated Record Set, (c) is not available for inspection because of an appropriate denial, or (d) if the information is accurate and complete. Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue your medical records. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we not have the correct information.

ACCOUNTING OF CERTAIN DISCLOSURES: The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, healthcare operations, or made via an authorization signed by you or your representative. Please submit a writer period we are permitted to charge for the cost of providing that list. If there is a charge we will notify you and you may choose to withdraw or modify your request before costs are incurred.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER HEALTH-RELATED BENEFITS: We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives or health-related benefits and services that may be of interest to you.

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COMPLAINTS: If you are concerned that your privacy rights have been violated, you may contact the Office Manager. You may also send a written complaint to the U.S Department of Health and Human Services: We will not retaliate against your for filing a complaint with the government or us. The contact information for the U.S. Department of Health and Human Services, HIPAA Complains, 7500 Security Blvd., C5-24-04, Baltimore, MD 21244.

OUR PROMISE TO YOU: We are required by law and regulation to protect your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

QUESTIONS AND CONTACT PERSON FOR REQUEST: If you have any questions or want to make a request pursuant to the rights described above please contact the Office Manager at: 9707 Anderson Mill Road, Suite 100, Austin, TX 78750. This notice is effective on the following date July 26, 2016. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice where it can be seen.

ACKNOLWEDGEMENT OF REVIEW OF PRIVACY PRACTICES: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

NAME (of patient or personal representative): ____

SIGNATURE: ______________________________ DATE: ____________________________

Description of personal representative's authority: ________________ DATE: ______________

FINANCIAL AND INSURANCE POLICIES

As a service to our patients, we will file insurance claims to the companies we are contracted with for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does NOT release the patient from responsibility of incurred charges for services which have been provided.

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All fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made in advance. We accept cash or personal check. ***In the event that we receive a returned check, a fee of $25.00 will be charged to your account and payment in full is due upon receipt of your statement.***

If you have health insurance you are responsible for:

- Verifying with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Knowing what your policy covers and what it does not. We cannot quote your benefits. Any disputes about payment must be resolved between you and your insurance company.
- Providing accurate insurance information within 15 days from the date of service. Failure to do so will result in the balance becoming your responsibility.
- Paying our office for any deductible, co-payment or non-covered charges on the day services are rendered.

If you DO NOT have health insurance, you are responsible for:

- Payment for the office visit and all diagnostic services the day the service is provided

STATEMENTS

Unless specific arrangements have been made in advance for an extension of time, charges for services not covered by insurance are due upon receipt of a patient statement. Statements showing the status of your account are mailed monthly. Accounts which are not paid within 90 days of statement receipt are subject to placement with an outside collection agency.

ASSIGNMENT OF BENEFITS

I hereby give authorization for payment of insurance benefits to be made directly to Retina Research Center, PLLC for services rendered. I authorize release of information necessary to file a claim with my insurance company or medical assistance program and assign benefits payable to me, to the doctor, or group indicated by the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I HAVE READ AND UNDERSTAND THESE POLICIES AND I AGREE TO BE BOUND BY ITS TERMS.

Signature:___________________________________ Date: ______________________

Authorization to Disclose Health Information

Date: ____

Patient Name:______________________________________

To:____

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Address: ____

____

Please release the following:

___Entire Record

OR: ___Exams ___Progress Notes
___Lab Reports ___List of Allergies
___Fundus Photos ___Medication List
___Fluorescein Angiogram ___Dictation

I hereby authorize Retina Research Center, PLLC to the use or disclosure of information contained in my medical record.

I understand that the information in my health record may include information relating to sexually transmitted infections, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present written revocation to the individual or organization releasing this information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply when it is lawfully necessary to release my medical information.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 of the Health Insurance Portability and Accountability Act (HIPAA)

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality guidelines.

____
Patient's Signature (or Legal Guardian/Power of Attorney)

____
Patient's Name Printed

____
Patient's Date of Birth

Name: ____

Date of birth: ____/______/______

SSN: _____-________-_______

Address: ____

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Gender: ❑Male ❑Female

Ethnicity:
❑ Hispanic/Latino
❑ Not Hispanic/Latino
❑ Not Reported
❑ Unknown

Race:

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Unknown

Language: ❑ English ❑Spanish ❑ Other____________

Home phone #: ______________________

Cell phone #: _____________________________

Alternate contact name, relationship and phone #: ___________________________________

E-mail: __________________________________

Fill in the information below and please provide the following cards please so that we can make a photocopy:
Driver License or other ID#: ___________________________

Medical Insurance Primary (name, ID, group ID): ______________________________

Medical Insurance Secondary (name, ID, group ID): ___________________________