# Center For Retinal Diseases and Surgery LLC

**LAST NAME** **FIRST** **MI** **SEX(M/F)**

**ADDRESS** **CITY** **STATE** **ZIP CODE**

**DATE OF BIRTH** **SOCIAL SECURITY #** **MARITAL STATUS**

**HOME PHONE** **WORK PHONE** **CELL PHONE**

**EMERGENCY CONTACT NAME** **PHONE NUMBER**

**PRIMARY CARE DOCTOR** **PHONE NUMBER**

**WHO REFERRED YOU TO OUR OFFICE?:**_____

**RACE:** ○**American Indian or Alaska Native** ○**Asian** ○**Black or African American** ○**Native Hawaiian or Other Pacific Islander** ○**White**

**ETHNICITY:** ○**Hispanic or Latino** ○**Not Hispanic or Latino** **LANGUAGE:**_____

**PRIMARY INSURANCE NAME:**_____

**Policyholder's Name:**_____ **Group #:**_____ **ID#:**_____

**Relationship to Patient:**_____ **DOB:**_____**Employer Name:**_____

**SECONDARY INSURANCE NAME:**_____

**Policyholder's Name:** _____ **Group #:**_____**ID#:**_____

**Relationship to Patient:**_____ **DOB:**_____**Employer Name:**_____

**I authorize CRDS, LLC to apply for benefits on my behalf for services rendered. I request payment from my insurance company be made directly to CRDS, LLC. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. In the event that my bill remains unpaid, I understand that it may be sent to a collection agency, and any fees incurred by CRDS, LLC for the collection process will be my responsibility.**

**SIGNATURE OF SUBSCRIBER OR BENEFICIARY** **DATE**

Email address: _____ Revised: 10/01/12

# Center For Retinal Diseases & Surgery LLC
## Patient Medical History Record

_____
**Date**

_____
**Name** **Date of Birth** **Age**

**CIRCLE YES OR NO:**

**HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING?**

| | | |
|---|---|---|
| **DIABETES** | **YES** | **NO** |
| **HIGH BLOOD PRESSURE** | **YES** | **NO** |
| **HEART DISEASE** | **YES** | **NO** |
| **STROKE** | **YES** | **NO** |
| **ARTHRITIS** | **YES** | **NO** |

**HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE DISEASES?**

| | | |
|---|---|---|
| **MACULAR DEGENERATION** | **YES** | **NO** |
| **DIABETIC RETINOPATHY** | **YES** | **NO** |
| **CATARACT** | **YES** | **NO** |
| **GLAUCOMA** | **YES** | **NO** |
| **WANDERING OR LAZY EYE** | **YES** | **NO** |

**PLEASE LIST ALL OF YOUR MEDICATIONS:**

_____

_____

_____

**PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR FOODS:**

_____

_____
**Patient's signature**

_____
Physician's signature

Center for Retinal Diseases and Surgery, LLC
Stephen S. Pappas, Jr., M.D.

# CONSENT FOR EYE DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to better view the inside of your eye.

These drops frequently blur your vision for a few hours. These effects will vary from person to person and may make bright lights bothersome. It is not possible for Dr. Pappas, Jr. to predict how much your vision will be affected. Because driving may be difficult immediately following an examination, you may wish to make arrangements for a driver. After you are dilated we will provide you with sunglass protection which you should use when you leave our office.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and is treatable with immediate medical attention.

I hereby authorize Dr. Stephen S. Pappas, Jr., and/or his designees, to administer eye drops now and in the future. I understand that these eye drops are necessary to diagnose my condition.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

# Center for Retinal Diseases and Surgery, LLC
# 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.**

## UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record and serves as a basis for planning your care and treatment as well as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

## OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health information. In addition, we are required to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and make the new provision effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described within this notice.

## YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. The information contained within your health record belongs to you. You have certain rights, described in detail below, related to how this information is used and disclosed. Your rights include the right to inspect and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information, except to the extent that such use or disclosure has already occurred.

The following pages provide you with information on your health information rights as well as examples as to how we use and disclose your health information for treatment, payment and health operations.

Please review this privacy notice carefully and call Julie Spiropoulos at (301) 571-2000 if you have any questions or would like additional information about our privacy policies.

## YOUR HEALTH INFORMATION RIGHTS:

*Right to obtain a Copy of This Notice of Privacy Practices*
This organization is required to maintain the privacy of your health information. We are required to provide you with a Notice of Privacy Practices with respect to the information we collect and maintain about you in your health record. We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, a revised copy of our current Notice will be available at our front desk or upon request. To request a copy of our current Notice of Privacy Practice, please call (301) 571-2000.

*Right to See and Copy Your Health Record*
You have the right to look at and receive a copy of your health record. If you need a copy of your health record, you will need to complete an authorization form. A fee may be charged for the cost of copying or mailing your record, as permitted by law. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

*Right to Update Your Health Record*
If you believe that a piece of important information is missing from your health record, you have the right to request that we add an amendment to your record. Your request must be in writing, and it must contain the reason for your request. We may deny your request to amend your record if the information being amended was not created by us, if we believe that the information is already accurate and complete, or if the information is not contained in records that you would be permitted by law to see and copy. Even if we accept your amendment, we will not delete any information already in your records.

*Right to Get a List of the Disclosures We Have Made*
You have the right to request a list of the disclosures that we have made of your health information. This list will not contain disclosures we have made for the purposes of treatment, payment and health care operations. It will not contain disclosures that were authorized by you, and certain other disclosures excluded by law. The list will not contain disclosures that were made before April 14, 2003. Your request must be in writing. The first list you request in a 12-month period is free. For additional lists, we may charge a fee, as permitted by law.

*Right to Request a Restriction On Certain Uses or Disclosures*
You have the right to request that we limit how we use and disclose your health information. We will consider your request, but we are not legally required to accept it. If we do accept it, we will comply with your request, except if you need emergency treatment. Your request must be in writing.

*Right to Choose How You Receive Your Health Information*
You have the right to request that we communicate with you in a certain way, such as

by mail or fax, or at a certain location, such as a home address or a post office box. We will try to honor your request if we reasonably can. Your request must be in writing, and it must specify how or where you wish to be contacted.

*Your Written Authorization*
We will not use or disclose your health information without your authorization except as described in this notice. Other uses and disclosures of your health information, not covered by this Notice, or the laws that govern us, will be made only with your written authorization. You may revoke your authorization in writing at any time, and upon receipt of your written revocation, we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that we already made with your authorization.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM:**
If you have questions and would like additional information, you may contact Julie Spiropoulos at (301) 571-2000. If you believe your privacy rights have been violated, you can file a written complaint with us or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS**
*We will use your health information for treatment. For example:* Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your other practitioners with copies of various reports that should assist them in treating you.

*We will use your health information for payment.* For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health operations*. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

*Business Associates:* There may be some services provided in our organization through contracts with Business Associates. Examples of Business Associates include: transcription services and answering services. When these services are contracted, we may disclose some or all of your health information to our Business Associates so that

they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

*Directory (inpatient settings):* Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location, and general condition.

*Communication with family:* Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

*Research (inpatient):* We may disclose information to researchers when an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

*Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

*Organ procurement organizations:* Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

*Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*Fund raising:* We may contact you as part of a fund-raising effort.

*Food and Drug Administration (FDA):* As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

*Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury, or disability.

*Correctional institution:* Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

*Notice of Privacy Practices availability:* This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy.

**Effective: April 14, 2003**

**Signature/Date:**_____