CENTER FOR
RETINAL DISEASES & SURGERY, LLC
STEPHEN S. PAPPAS, JR., M.D., FACS
Continuing a tradition of excellence in personalized retinal care

MEDICAL HISTORY QUESTIONNAIRE

Last name _____**First Name** _____**MI** ___ **DOB**_____

Please answer the following questions about your current eye problems and medical history:

1. What problems are you **CURRENTLY** having with your eyes?

		Which eye?	When did the trouble begin?
____floaters/spots	____pain		
____flashing lights	____sensitivity to light/glare	Right	
____blurred vision	____poor depth perception		_____
____distortion/waviness	____trouble with colors	Left	
____loss of side vision	____other		

2. Please list **ALL** of your medications (including eye drops) and the **dosage:**

_____
_____
_____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, asthma, stroke, arthritis ect.,)?

_____ Yes _____ No If yes, please explain: _____

_____
_____

4. Have you had any eye problems in the past (e.g., cataract, glaucoma, retina problems, eye surgery, macular degeneration, diabetic retinopathy etc.)?

_____ Yes _____ No If yes, please explain: _____

_____
_____

5. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

_____ Yes _____ No If yes, please explain: _____

_____
_____

6. Do you operate a vehicle? ____ Yes ____No

7. Do you have visual difficulty when driving? ____ Yes ____No

8. Do you have problems with your night vision? ____ Yes ____No

MEDICAL HISTORY QUESTIONNAIRE CONTINUED

9. Have you had any of the following problems?

Chronic fever, unexpected weight loss/gain, fatigue?	____Yes ____No	If yes, please explain:
Ear/nose/throat problems (e.g. hearing loss, sinus problem)?	____Yes ____No	If yes, please explain:
Heart problems (e.g. chest pain, irregular heartbeat)?	____Yes ____No	If yes, please explain:
Respiratory problems (e.g. shortness of breath. Wheezing, asthma, bronchitis)?	____Yes ____No	If yes, please explain:
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?	____Yes ____No	If yes, please explain:
Urinary problems (e.g. pain or discomfort, bladder infections)?	____Yes ____No	If yes, please explain:
Skin diseases (e.g. rashes, eczema, dermatitis)?	____Yes ____No	If yes, please explain:
Musculoskeletal problems (e.g. muscle aches arthritis, swollen joints)?	____Yes ____No	If yes, please explain:
Neurologic problems (e.g. numbness, weakness, paralysis, headaches)?	____Yes ____No	If yes, please explain:
Psychiatric problems (e.g. depression, anxiety)?	____Yes ____No	If yes, please explain:

10. Do you have any allergies to medications or foods?

_____

_____

_____

_____

11. Do you have a latex allergy? ____Yes ____No

12. Have you had a blood transfusion? ____Yes ____No

13. Do you smoke? ____Yes ____No If yes, how much? _____

14. Do you drink alcohol? ____Yes ____No If yes, how much? _____

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REQUEST TO RELEASE MEDICAL RECORDS
Use and Disclosure of Protected Health Information

Patient's Name _____ Medical Record or Social Security # _____

1. Persons or group of persons authorized to **use/disclose** this information

Center For Retinal Diseases and Surgery, LLC 6420 Rockledge Drive Suite 4900 Bethesda, MD 20817

2. Persons or group of persons authorized to **receive** this information:

Name:_Self_____Relationship_Self_____ Name:_____Relationship_____ Name:_____Relationship_____

3. Description of the information to be used or disclosed:

Medical Records

4. Purpose for disclosure of information:

Personal

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations. _____ **(Patient Initials)**
6. I understand that I may revoke this authorization in writing at any time. Please refer to CRDS, LLC's "Notice of Privacy Practices". I understand that CRDS, LLC will be unable to take back any disclosures that were made prior to my written revocation of this authorization. _____ **(Patient Initials)**
7. I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits.* _____ **(Patient Initials)** *This section would only apply if the request for the disclosure of the information was not initiated by the patient.
8. I understand that I may inspect or copy any information used or disclosed under this authorization. _____ **(Patient Initials)**
9. This authorization becomes effective _____ and will expire on _____.

_____ _____
Patient (or Representative*) Signature **Date**

_____ _____
Name of personal Representative (Please Print) **Relationship to Patient**

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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 closer 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

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Revision: September 23, 2013
Effective Date: September 23, 2013

This information is made available upon request by a patient

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure of all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a glaucoma specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice such as conducting quality assessments and improving activities, auditing functions, cost management analysis and customer service. An example of this would be new patient survey cards.

- This Practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain to you if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the Notice of our legal duties and our privacy practices with respect to PHI.

This notice is effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provision effective for all PHI that we maintain. We will post, and you my request, a written copy of the revised Notice of Privacy Practices from our office. You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the office’s Practice Compliance Officer, in person or in writing for more information.

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Dr. Stephen S. Pappas, Jr., M.D., FACS. I hereby acknowledge receipt of Center For Retinal Diseases and Surgery, LLC's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name}. I hereby acknowledge receipt of Center for Retinal Diseases and Surgery, LLC's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: _____ Parent _____Legal Guardian

Signature: _____

Date: _____