Alliance Retina

Kim-Binh Mai, MD
Vitreoretinal Surgery and Diseases

PATIENT INFORMATION			
Patient's first and last name:	Marital Status:		
Former maiden name:	Birth Date:	Age:	Gender: ☐ M ☐ F
Address (Street Name, City, Zip Code):			
Social Security No.:	Home Phone:	Cell Phone:	
Occupation:	Employer:	Work Phone:	
Email address:			

Race: (required by federal HIPAA regulations)

☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Black or African American
☐ Hispanic
☐ Other
☐ Unknown

IN CASE OF EMERGENCY			
Emergency contact's full name:	Relationship to patient:	Cell Phone:	Work Phone:

PREFERRED PHARMACY	
Name:	Phone:
Address:	Fax:

PRIMARY CARE PHYSICIAN		
Name:	City:	Phone:
Address:		Fax:

OPTOMETRIST		
Name:	City:	Phone:
Address:		Fax:

REFERRING PHYSICIAN		
Name:	City:	Phone:

PRIMARY INSURANCE INFORMATION		
(please bring your insurance card(s) to your appointment and give it to the receiptionist)		
Primary Insurance Company:		Effective Date:
Subscriber's Full Name:		Birth Date:
Subscriber's SSN:	Patient's relationship to Subscriber:	
Group No.:	Policy No.:	Copay: $

SECONDARY INSURANCE INFORMATION		
Secondary Insurance Company:		Effective Date:
Subscriber's Full Name:		Birth Date:
Subscriber's SSN:	Patient's relationship to Subscriber:	
Group No.:	Policy No.:	Copay: $

WORKERS' COMPENSATION INFORMATION (complete only if injured at work)	
Employer at time of accident:	Date of injury:
Address:	Phone:
Insurance Company:	Phone:
Insurance Company Address:	
Claim Number:	Name of Adjustor:

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Patient's full name: **Date:**

MEDICAL HISTORY QUESTIONNAIRE

The Health Care Financing Administration requires we obtain the following information from you to be in compliance with their patient history guidelines for billing consultation services. If you have any questions regarding this form or need assistance, please let our staff know.

What symptoms or complaints do you have with your vision (please be specific, including dates)?

List all major illnesses and injuries that you have had in the past:

List any surgeries (including on your eyes) that you have had in the past:

List any medications (including any eye medications) that you take:

List any allergies you have (including medication allergies):

Do you presently have any problems with the following areas?

Integument (skin)	☐ YES	☐ No	☐ YES	☐ No	Neurological
Ears, Nose, Mouth, Throat	☐ YES	☐ No	☐ YES	☐ No	Lymph Nodes
Respiratory (lungs)	☐ YES	☐ No	☐ YES	☐ No	Hematopoietic (blood)
Cardiovascular (heart)	☐ YES	☐ No	☐ YES	☐ No	Allergic / Immunologic
Gastrointestinal (stomach)	☐ YES	☐ No	☐ YES	☐ No	Genitourinary
Bones, Joints, Muscles	☐ YES	☐ No			

Do you drink alcohol? ☐ YES ☐ No

Do you smoke? ☐ YES ☐ No

Are you taking blood thinners? ☐ YES ☐ No If yes, what are you taking? _____

Do you think you may have been exposed to HIV? ☐ YES ☐ No

_____

Patient/Guardian Signature

KIM-BINH MAI, MD
VITREORETINAL SURGERY & DISEASES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____ (Please print patient name) have been provided a copy of Alliance Retina's Notice of Health Information Practices and Notice of Financial Policy.

I have had an opportunity to read the Notice of Health Information Practices and Notice of Financial Policy.

I understand that I may ask question if I do not understand any information contained in the Notice of Health Information Practices and Notice of Financial Policy.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed Name

NOTICE OF FINANCIAL POLICY

1. **All Co-Pays and Co-insurance required by your insurance company must be paid at the time services are rendered**. We accept cash, check, and all major credit cards. Post-dated checks will not be accepted by our office. There is a $25 service charge for all returned checks. After receiving a returned check, Alliance Retina of Texas will only accept cash, money order or debit/credit card for payment.

2. Please be prepared to provide our office with a copy of your insurance card(s) and picture identification at each appointment. It is the patient's responsibility to notify our office if your contact information has changed. It is also the patient's responsibility to notify our office of any insurance changes **PRIOR** to your visit. You may be responsible for any services or treatments provided if we were not made aware of such changes and your insurance requires a prior authorization. Unauthorizes services will be the patient's responsibility in such cases. We recommend patient's to be aware of his/her insurance plan benefits including any co-payment or deductible obligation.

3. Physician surgical fees owed are due prior to any surgery performed by the doctor(s) in the various facilities we perform surgery in. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the **Surgeon ONLY**. The facility where the operation is performed is responsible for quoting and collecting payment for their FACILITY fees. It is your responsibility to contact the surgery facility to obtain their fees and make payment arrangement **prior to the date of surgery**.

4. Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.

5. Any **PAST DUE BALANCE** is required to be paid upon receipt of our billing statement or at the next visit. In the event your account becomes delinquent, we will take the necessary steps to collect the debt, or refer to a collection agency, which could negatively impact your credit.

6. **SELF PAY/CASH PAY POLICY**: For patients who are using cash for their office visit, a PAYMENT IN FULL will be due at the time of service, unless other payment arrangements have been made with our billing department. We also accept CARE CREDIT and can assist with the credit application.

7. For FMLA and other leave related paperwork, there will be a $25 processing fee to complete such forms.

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NOTICE OF HEALTH 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.

USES AND DISCLOSURES

TREATMENT. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTHCARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of Alliance Retina of Texas PLLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

ADDITIONAL USE OF INFORMATION

APPOINTMENT REMINDERS. Your health information will be used by our staff to send you appointment reminders.

INFORMATION ABOUT TREATMENTS. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health related products and services that we believe may interest you.

FUNDRAISING. We will not use your protected information for fund-raising efforts unless approved by you in writing for the specific fund-raising effort.

MARKETING. We will not use your protected information for marketing efforts unless approved by you in writing for the specific marketing effort.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect a copy of your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

ALLIANCE RETINA OF TEXAS PLLC'S DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected information, if your information has been compromised, it is our duty to notify you.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to you records by contacting our Medical Records department or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complain about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Alliance Retina of Texas PLLC
1007 W. Randol Mill Road Suite 110
Arlington, TX 76012

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

The effective date of this Notice is 07/10/2017.

Alliance Retina

HIPPA DISCLOSURE OF MEDICAL INFORMATION

I authorize the following person(s) to discuss my medical care, billing or insurance information, with the **Alliance Retina Of Texas PLLC** staff, on my behalf.

1) Name: _____ Ph: _____
Relationship: _____

2) Name: _____ Ph: _____
Relationship: _____

3) Name: _____ Ph: _____
Relationship: _____

This consent is given freely and I understand that I can revoke this consent at any time in writing.

By signing this form, I acknowledge I have received a copy of this Privacy & Financial disclosure as well as an opportunity to review this before signing.

Name: _____ Date: _____