

Chart No.  
Date

Patient Name \_\_\_\_\_  
First Middle Last

Patient Address \_\_\_\_\_  
Street Add2 City State Zip

Telephone No. \_\_\_\_\_  
Home Work

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Driver's Lic. No. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

Referring Physician Phone Number \_\_\_\_\_

Referring Physician Address \_\_\_\_\_  
Street Add2

City State Zip

Name of your primary care physician/internist \_\_\_\_\_

Phone no. and Address of your primary care physician/internist ( ) \_\_\_\_\_

**Responsible Party**

Name of Responsible Party:(Self;Spouse; Parent) \_\_\_\_\_  
Circle

Social Security No. \_\_\_\_\_ Driver's Lic. No. \_\_\_\_\_

Billing Address \_\_\_\_\_  
Street Add2 City State Zip

Telephone No. \_\_\_\_\_  
Home Work

**Please be aware that we do not treat worker's compensation (work) related injuries or automobile related injuries. If your visit today is related to a work or automobile injury please inform the receptionist so we can assist you in locating another retina specialist that can treat your injury.**

**Insurance information authorization / assignment of benefits**

*I authorize Retina Institute of Texas, P.A. to release any information regarding my present illness or injury which my insurance company may request. I understand that the information disclosed may include references to or treatment of alcohol/drug abuse, psychological illness, or HIV testing. I will hold Retina Institute of Texas, P.A., its agents, my physician, and his associates blameless from any claim of liability arising out of the disclosure and/or release of such information. I assign to Retina Institute of Texas, P.A. all payments to which I am entitled for medical and/or surgical expenses for the services reported. I understand that I am financially responsible to Retina Institute of Texas, P.A. for charges not covered by this assignment of benefits.*

Please Sign Here \_\_\_\_\_ Date \_\_\_\_\_

## Patient Personal History

This form will become part of your medical record which is considered CONFIDENTIAL.

Chart No.  
Date  
Name  
DOB

List any medication allergies: \_\_\_\_\_

List current medications: \_\_\_\_\_

Previous Surgeries: Ocular (eye) \_\_\_\_\_

Nonocular \_\_\_\_\_

## PERSONAL HISTORY

Please check any of the following conditions you have or have had:

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Heart Attack/Heart Disease                |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Swollen Legs                              |
| <input type="checkbox"/> Seizures or Epilepsy         | <input type="checkbox"/> Heart Murmur                              |
| <input type="checkbox"/> TB (tuberculosis)            | <input type="checkbox"/> Back Pain                                 |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Arthritis                                 |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Ulcer                        | <input type="checkbox"/> Headaches                                 |
| <input type="checkbox"/> Any Incurable Disease        | <input type="checkbox"/> Blood Disorder/Bleeding                   |
| <input type="checkbox"/> Alcoholism                   | <input type="checkbox"/> Shortness of Breath                       |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Pneumonia                                 |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Anemia or Low Blood Count                 |
| <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Liver Problems or Jaundice                |
| <input type="checkbox"/> Recent 10 lb. Weight Change  | <input type="checkbox"/> Get Up at Night to Urinate                |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Kidney Trouble or Problems with Urination |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Breast or Testicular Lump                 |
| <input type="checkbox"/> Stools Black Like Tar        | <input type="checkbox"/> Loss of Appetite                          |
| <input type="checkbox"/> Moles Changing               | <input type="checkbox"/> Elevated Cholesterol                      |
| <input type="checkbox"/> AIDS or HIV Positive         |  |

Please explain all items checked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Family History

Does any member of your family suffer from any of the conditions listed above? If so, list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Social History

Do you drink alcohol? \_\_\_ Yes \_\_\_ No  
How much? \_\_\_\_\_

Do you smoke \_\_\_ Yes \_\_\_ No  
How much? \_\_\_\_\_

Do you use other tobacco products? \_\_\_ Yes \_\_\_ No  
What? \_\_\_\_\_

## INFORMATION REGARDING DILATING EYE DROPS

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

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

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

I hereby authorize the physicians of Retina Institute of Texas, PA and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

\_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patient Name:

Chart#:

## HIPAA NOTICE OF PRIVACY PRACTICES RETINA INSTITUTE OF TEXAS, PA

3414 Oak Grove Ave. Dallas, TX 75204 214-521-1153 214-219-3651 Fax	400 W. Interstate 635 Plaza I, Suite 320 Irving, TX 75063 972-869-1242 972-869-2921 Fax	811 W. Interstate 20 Suite GL26 Arlington, TX 76017 817-417-7769 817-417-7405 Fax	3331 Unicorn Lake Blvd. Denton, TX 76210 940-381-9100 940-381-9106 Fax	Maurice G. Syrquin, M.D. Gregory F. Kozieliec, M.D. Marcus L. Allen, M.D. S. Robert Witherspoon, M.D.
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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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services."

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use as required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example of disclosure would be providing your information to the physician that referred you to us or to a physician that we refer you to, ensuring that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in the office and/or who review your history through study group discussions and research projects. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in certain situations without your authorization. These situations include: as Required by Law (Public Health Issues, Communicable Diseases, Health Oversight): Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funderal Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your requested health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to receive confidential communication from us by alternative means or at an alternative location.** **You have the right to obtain a paper copy of this notice from us.** upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

**You have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may file a complaint to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Debbie Alfstad in person or by phone at 214-521-1153.

Please list any persons (family members, friends) with whom we may speak regarding issues concerning your protected health information.

\_\_\_\_\_  Medical  Billing

\_\_\_\_\_  Medical  Billing

\_\_\_\_\_  Medical  Billing

Signature below is only acknowledgment that you have received the Notice of Privacy Practices.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness