Retina & Vitreous

of Louisiana

(PLEASE PRINT)

Referred by: _____ Patient #:

office use only

Patient Demographics

Sex ☐ M ☐ F

_____

Last Name First Name Middle Date of Birth

_____

Mailing Address City State Zip

_____

Social Security # Home Phone # Cell Phone # Work Phone #

_____

Occupation Employer

Best contact #
☐ Cell ☐ Work ☐ Home

_____

Employer Address City State Zip

Alternate Contact

_____

Name of Contact Phone # Relationship

Insurance

_____

Policy Holder Address City State Zip Phone #

_____

Date of Birth Social Security # Employer Phone #

_____

Primary Insurance Company Secondary Insurance Company

I authorize the release of any medical information necessary to process Medicare, Medicaid or insurance claims and authorize payment directly to Retina and Vitreous of Louisiana of Medicare / Medicaid benefits or medical and surgical benefits of my insurance policy(s).

I have received or refused a copy of Retina and Vitreous Privacy brochure.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Responsible Party

Revised 4/2013

Retina & Vitreous

of Louisiana

PATIENT CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Why should I fill out this form?

- If you want anyone other than yourself to be able to discuss your care with us over the phone or in person without being present.
- Due to federal privacy laws (HIPAA – Health Information Portability and Accountability Act) we cannot release medical information except to other health professions involved in your care without your consent.

Please indicate what information you would like us to share:

Appointments:	YES ___ NO ____
Medication:	YES ___ NO ____
Billing:	YES ___ NO ____
Current Medical Status	YES ___ NO ____

I give permission to share the above information with the person(s) listed below:

Name: _____

Relationship: _____

_____ _____

PATIENT SIGNATURE or REPRESENTATIVE DATE

_____

PRINTED NAME of REPRESENTATIVE

_____

RELATIONSHIP of REPRESENTATIVE

Referring physician: _____ Primary care physician: _____

Office Use Only:

PATIENT HISTORY

Family History: Do you have any medical or eye diseases that run in your family? (Examples: Diabetes, High Blood Pressure, Cancer, Glaucoma, Macular Degeneration)

Medical History: Please briefly list any past medical problems that you have had:

Surgical History: Please list any surgeries you have had:

- Have you ever had any complications with anesthesia? □ Yes □ No

Social History: Do you Smoke or use tobacco products? □ Yes □ No If yes, how much?_____
Do you Drink Alcohol? □Yes □ No If yes, how much? _____

Allergies: Please list any medications you are allergic to:

□**None**

Medications: Please list any medications you are taking, **especially** eye drops: ***(Please allow us to copy your list if you have one)*** □ **See list** □None

Preferred pharmacy name: _____ Location: _____

D.O.B

Patient Name:

Review of Systems

Do you **CURRENTLY** have any of the following problems? If "yes", please circle or list in the space provided.

Constitutional (Fever, Unintentional weight loss)	□ Yes □ No	
Eyes (Glaucoma, Lazy eye, Retina problems)	□ Yes □ No	
Ear/Nose/Throat (Hearing loss, Sinus problems)	□ Yes □ No	
Cardiovascular (Heart problems, High blood pressure. Chest pain, Irregular heartbeat)	□ Yes □ No	**Name of Cardiologist**: _____
Respiratory (Asthma, shortness of breath)	□ Yes □ No	
Gastrointestinal (Heartburn, Abdominal pain, vomiting)	□ Yes □ No	
Genitourinary (Kidney stones, Kidney failure, dialysis)	□ Yes □ No	**Are you on dialysis? □ Yes □ No**
Integumentary (Skin Rashes, skin cancers)	□ Yes □ No	
Musculoskeletal (Joint pain, Swollen joints, Rheumatoid arthritis)	□ Yes □ No	
Neurologic (Numbness, Paralysis, Headaches, Multiple Sclerosis, stroke)	□ Yes □ No	
Hematologic/Lymphatic (Blood disorders, Leukemia)	□ Yes □ No	
Allergic/Immunologic (Hay fever, Allergies)	□ Yes □ No	
Endocrine (Thyroid problems, Diabetes)	□ Yes □ No	
Psychiatric (Anxiety, Claustrophobia, Depression)	□ Yes □ No	

Physician Signature: _____ Date: _____

Retina & Vitreous

of Louisiana

Welcome to Retina & Vitreous of Louisiana. We are pleased that you have selected our office for your care. Please take the time to read the following policies.

Appointments

- You have come to see us for a vitreoretinal condition. Vitreoretinal conditions are examined by looking through the pupil. Dilating eye medications are necessary to perform an examination through the pupil in order to diagnose and treat your condition. Please remember that you will be dilated for most appointments. Eye dilation typically lasts around 6 hours and should not affect your distance vision but may blur your near vision.
- We ask that you arrive at our office on time for your appointment. If you are more than 15 minutes late for your appointment time, you may be asked to reschedule to a later date.
- We will make our best effort to honor your scheduled appointment time. However, there may be unforeseen delays due to emergencies and surgeries. We hope that you understand that this may occur and we will notify you so that you can make the decision to wait or to reschedule your appointment.

Cancellation/Missed Appointments

- We request that if you are unable to make your scheduled appointment time that you extend the courtesy of notifying our office no later than 24 hours prior to your appointment. Our doctors have reserved that time to provide you personalized quality care. You will be notified of missed appointments; if you miss more than three appointments without contacting our office, you may be discharged from care with Retina & Vitreous of Louisiana.

Insurance Filing

- As a courtesy, we will file your insurance claims with your carrier. We accept most major medical plans, Medicare, and Medicaid. Please check with our billing department if you have any questions. Please be aware that it is your responsibility to know your benefit coverage. Your insurance may not pay for all services provided by Retina & Vitreous of Louisiana and you will be financially responsible for the services not paid by your carrier.
- Please note that it is your responsibility to make sure that we have the most up to date insurance information. Please notify our office of any changes to your information prior to your appointment.

Payments

- Copayments and coinsurance payments are expected at the time of service. If you do not have insurance, a minimum payment of $250 is expected at the time of service. You will receive a statement for any additional charges above $250.

    - Copayment – Your financial responsibility as agreed upon with your insurance carrier for office visits. Typically between $20 and $50, depending on your plan.

    - Coinsurance – The percentage of the cost of surgical procedures that you are financially responsible for. Typically 20% of the cost of the procedure after meeting your deductible for the year. *Examples – in-office lasers and injections, surgeon fees for procedures performed in the operating room.*

Patient Inquiries

- If you have a non emergent issue during regular business hours, you can leave a message for the Doctors with the technicians. All calls received by 4pm will be returned by the end of the business day. Calls received after 4pm will be returned the next business day.

After Hours and Emergency Problems

- In the event of an emergency, please call our office and the answering service will notify the physician on call.