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Welcome to Retina Vitreous Center!

To help expedite your visit with us, please read and complete the attached forms, and bring them with you to your appointment.

Please remember to include a list of the medications you are currently taking or alternatively, you may bring them with you to your visit. If you have any concerns about answering any of the questions, we will be happy to assist you when you arrive at our office.

Thank you for selecting us to provide your retinal care.

Information Regarding Dilation Drops

Dilating drops are used to dilate (enlarge) the pupils of the eye to allow the doctors to get a better view of the inside of your eye.

Dilating drops frequently blur vision. The dilation time varies from person to person and may make bright lights bothersome.

It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is 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.

Please read and sign below:

I hereby authorize Retina Vitreous Center (RVC) physicians or their assistants as may be designated to administer dilating eye drops. I understand that the eye drops are necessary to diagnosis my condition.

X _____ _____

Patient (or person authorized to sign for patient) *Date*

X _____ _____

Witness *Date*

Retina Vitreous Center Policies

OFFICE HOURS

Our office is open Monday through Friday from 7:50 am until 5:00 pm, excluding holidays. In the event of a medical emergency, please go to the Emergency Room! *Prescription refills are not considered an emergency.*

APPOINTMENTS

On every visit please bring with you a list of any medication you are currently taking, including over-the-counter supplements or vitamins. We make every effort to schedule patients at the earliest possible opening. Should you need to cancel or reschedule, we ask that you give us at least 24-hours notice so that we can move another patient to that time slot.

We may assess a **$15 fee** for appointments not cancelled within 24 hours, and we may charge a **$25 fee** for a "no show" (missed appointment with no notice). Your insurance will not pay for these charges and you may be required to pay any such fees prior to being seen at your next appointment.

PRESCRIPTION REFILLS

Good medical care requires that a physician review a patient's chart prior to refilling or amending a prescription. For this reason, we require our patients to request refills at least 48 hours in advance of the need. We ask that you contact your pharmacy with your request, and allow the pharmacist to contact our office. Please check directly with the pharmacy to see if your refill has been approved—and remember to allow 48 hours! If you called on Friday or a holiday, you may check with your pharmacy on the next business day after 4 pm.

PAYMENT POLICY

- Residual balances, copayments and deductibles are due at the time of service.
- Our returned check fee is $25. We participate with the Oklahoma County DA in the collection of returned checks.
- Patients with no health insurance will be required to pay $250 at the first appointment. This amount is NOT payment in full. Additional diagnostic tests or treatment will result in additional charges. If payment in full for the additional charges cannot be made at the time of service for the "private pay" patient, he or she is asked to call our billing office at 405-292-5500 (Option 2) to make suitable payment arrangements. A monthly payment is required to keep the account current.

FORMS

Disability policies are private policies owned by the patient. We charge $25 for a single disability form and $15 each for additional forms when provided at the same time to be completed. Without exception the money must be prepaid at the time the form is left with our office. FMLA forms are not disability forms, and require more time and detail to be completed. Our charge for completing the FMLA form is $50. We may require up to 10 days to complete any forms. Patients may come by to retrieve their form/s, or they may provide our office with a stamped, self-addressed envelope and they will be forwarded as indicated.

Signature: _____ Date: _____

RVC RETINA VITREOUS CENTER

Patient Data Sheet

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W Sex: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS# _____ E-mail: _____

Employer: _____ Job Title: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Responsible Party / Insurance Policy Holder (if different from patient information)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# _____ Date of Birth: _____/_____/_____ Phone#: _____

Employer: _____ Employer phone: _____

Insurance Information

Primary Insurance: _____ I.D.#: _____ Group #: _____

Secondary Insurance: _____ I.D. #: _____ Group #: _____

Insurance Address: _____ Phone: ( ) _____

Pharmacy Info	Primary Care Physician Info	Eye Doctor Info
Name:	Name:	Name:
Address:	Phone #:	City:

Emergency Contact Information

Name: _____ Relationship: _____ Phone#: _____

HIPPAA—I authorize RVC/billing company to contact me about my bill by reaching me via
(Note: if no boxes are checked, we will require prepayment on all services).

☐ Phone ☐ Cell ☐ Work phone ☐ Mail

Required Authorizations (*complete all of the consents)

Authorize Payment / Release of Information: I hereby authorize payments directly to RVC of the surgical and/or medical benefits. I understand that I I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract. I also agree to the RVC Cash/Insurance Payment Policy which authorizes release of information necessary to file insurance claim or filing a payment for review.

X _____ _____

Patient Signature (or parent of minor) *Date*

I have received a Notice of Privacy Practices from RVC.

X _____ _____

Patient Signature (or parent of minor) *Date*

I have signed the patient consent for use and disclosure of protected health information from RVC

X _____ _____

Patient Signature (or parent of minor) *Date*

With my consent, Retina Vitreous Center, PLLC (RVC) may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Retina Vitreous Center, PLLC reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Name of Privacy Officer: Bonnie Pollock **Name of Practice:** Retina Vitreous Center, PLLC
Address: 1008 NW 139th St. Parkway **City, State, Zip:** Edmond, Oklahoma, 75013

Telephone/Text

With my consent, Retina Vitreous Center, PLLC may call my home or another designated location and leave a message (on voice mail, answering machine, in person, or by automated text message) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, Retina Vitreous Center, PLLC may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Retina Vitreous Center, PLLC may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Retina Vitreous Center, PLLC restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Retina Vitreous Center, PLLC

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Retina Vitreous Center, PLLC may decline to provide treatment to me.

X _____

Print Patient's Name:

X _____ _____

*Signature of Patient * or Legal Guardian:* *Date:*

The goal of Retina Vitreous Center (RVC) is to provide our patients with exceptional care. For us to maintain this high standard of care, we require copayments, coinsurance amounts and insurance deductibles to be paid at the time services are rendered.

Your appointment today may be for an initial consultation; however, it may be medically necessary to perform additional testing. If you have questions about the cost, please ask any member of our staff, as you or your insurance company will be charged for services rendered.

If we do not participate with your insurance and they have not paid our claim within 60 days, the balance will be due in full from you. If you are unable to pay in full, we ask that you make payment arrangements to get the bill resolved as quickly as possible.

If our office is participating with your insurance, we will abide by the terms of our contract, but services not covered or deemed patient responsibility are due from you, and again, we ask that you resolve the balance as soon as possible.

Our office works diligently to identify programs of financial assistance to help our patients obtain needed medications. If you wish to know more about these resources, please ask any member of our staff. We accept VISA, MasterCard, Discover and American Express, as well as Care Credit.

Note:
We are happy to file any insurance on your behalf, but please be aware that **we do not participate in all plans.** If you are uncertain if our office participates in your plan, you should call the customer service number and ask them directly. Many companies are now offering multiple plans, and some have a closed network. We are not able to confirm or deny our participation with any certainty.

By signing below I acknowledge that I have read and understood the information presented.

X _____ _____

Signature of Patient *Date*

If I am not the patient, but instead signing on behalf of the patient, I certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions, including any and all payment obligations.

X _____ _____

Signature of Patient Representative *Date*

X _____

Relationship of Representative to Patient

REVIEW OF SYSTEMS

RETINA VITREOUS CENTER

NAME: _____

DATE OF BIRTH: _____

OCULAR HISTORY: *List any previous and/or current eye-problems & procedures (cataract, laser, lazy eye, trauma, etc.) Please specify which eye & include approximate procedure dates*

_____

_____

OCULAR MEDS: *Include any prescription or over the counter (artificial tears, vitamins, etc.) Please note which eye & frequency*

_____

CHECK BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

- ☐ *Flu Vaccination* in past year
- ☐ *Pneumonia Vaccination* in past 5 years
- ☐ AIDS/HIV
- ☐ Arthritis / RA
- ☐ Asthma/ COPD
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Migraines
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Thyroid Conditions
- ☐ Tuberculosis
- ☐ History of Plaquenil Use

Dates: _____

- ☐ Kidney Disease/Kidney Stones

Start of Dialysis: _____

- ☐ Cancer

Type: _____

Date Diagnosed: _____

- ☐ Diabetes

Type I or II: _____

Date Onset: _____

Any Complications: _____

Last Known A1C: _____

- ☐ Stroke

Date: _____

- ☐ Other: _____

ALL PREVIOUS SURGERIES & DATES:

_____

_____

CURRENT MEDICATIONS: *Include any prescription and/or over the counter*

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

DRUG ALLERGIES: ☐ NONE _____

FAMILY HISTORY: *Check box to indicate if any member of your FAMILY has had any of the following:*

	Relationship to patient		Relationship to patient
☐ Unknown Family History		☐ Retinal Detachment	_____
☐ Diabetes	_____	☐ Macular Degeneration	_____
☐ Glaucoma	_____	☐ Cancer	_____

SOCIAL HISTORY:

Fall Risk: ◯ No Falls in Past Year ◯ 1+ Falls in Past Year ◯ 2+ Falls in Past Year with Injury

History of Smoking: ◯ Never ◯ Former ◯ Current Light Tobacco User ◯ Current Heavy Tobacco User