Sandeep N. Shah, M.D.
Brian S. Phelps, M.D.

Phone: (405) 607-6699 Fax: (405) 607-6685
www.rvcoklahoma.com

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.

As this will be a dilated exam, we recommend that you have someone come with you who can drive you home.

Thank you for selecting us to provide your retinal care.

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or 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 for a length of time which 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 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.

Signed:

______________________________ __________________
Patient (or person authorized to sign for patient) Date

______________________________ __________________
Witness Date

Office Locations (directions on www.rvcoklahoma.com):
North OKC/Edmond: 1008 NW 139th St. Parkway, Edmond, OK 73013
Norman: 1125 N. Porter Ave., Suite # 100, Norman, OK 73071
Midwest City: 1455 S. Douglas Ave., Suite A, Midwest City, OK 73130
Elk City: 1710 W. 3rd Street, Suite 100, Elk City, OK 73644
Lawton: 5606 S. W. Lee Blvd., Suite 301, Lawton, OK 73505

Patient Data Sheet

First Name: ________________________ Middle Initial: _______ Last 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: (____) ______________
Employer Address: ______________________________ City: __________________ State:______ Zip: ______

Insurance Information

Primary Insurance: ______________________________ I.D.#: ___________________ Group #: ______________
Secondary Insurance: ______________________________ I.D. #:___________________ Group #: ______________
Insurance Address: ____ Phone: (____) __________________

Pharmacy Information

Preferred Pharmacy: ________________________ Address: ______________________________________

Emergency Contact Information

Relative/Friend whom we may contact in case of an emergency and/or about your visit if required (HIPPAA compliance):
1) ______________________________________ Relationship ______________ Phone#: ______________
2) ______________________________________ Relationship ______________ Phone#: ______________

Required Authorizations (*complete all of the consents)

Authorize Payment / Release of Information: I hereby authorize payments directly to Retina Vitreous Center (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 Retina Vitreous Center (RVC).

X____ ____________
Patient Signature (or parent of minor) Date

I have signed the patient consent for use and disclosure of protected health information from Retina Vitreous Center (RVC)

X____ ____________
Patient Signature (or parent of minor) Date

HIPPAA—I authorize RVC/billing company to contact me about my bill by reaching me via (Note: if all boxes are checked "no" we will require prepayment on all services). **Phone:** yes [ ] no [ ] **Cell:** yes [ ] no [ ] **Work phone:** yes [ ] no [ ] **Mail:** yes [ ] no [ ]

You may speak with the following person/s about my bill regarding medical services provided:
Name: ____ Relationship: ______________________ Phone (____) ____________

You may not speak with the following person/s about my bill regarding medical services provided:
Name: ____ Relationship: ______________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Retina Vitreous Center, PLLC 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:

Americo Alvarado Lewin	Retina Vitreous Center, PLLC
Name of Privacy Officer	Practice
1008 NW 139th Street Parkway	Edmond, OK 73013
Address	City, State, Zip

Telephone
With my consent, Retina Vitreous Center, PLLC may call my home or another designated location and leave a message (on voice mail, answering machine or in person) 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.

Print Patient's Name	Signature of Patient *or Legal Guardian*	Date

Cash Payment Policy
General Insurance Payment Policy

The goal of Retina Vitreous Center 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.

Signed: ____ 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.

Signed: ____ Date: ____________________

Relationship of Representative to Patient: ____

RETINA VITREOUS CENTER

Review of Systems

Name: ______________________
DOB: ________________________

Circle "Yes" or "No" to indicate if you had any of the following:

Yes No AIDS/HIV
Yes No Arthritis
Yes No Artificial Heart Valve
Yes No Artificial Joints
Yes No Asthma/COPD
Yes No Bleeding
Yes No Blood Clots
Yes No Cancer – If yes:
Type:_________________________
Date Diagnosed:_______________
Yes No High Cholesterol
Yes No Drug Dependency
Yes No Diabetes – If yes:
Date diagnosed:____________________
Date of insulin dependence:___________
Yes No Emphysema
Yes No Epilepsy
Yes No Hay Fever
Yes No Heart Condition –
If yes, what kind:____________________
Yes No High Blood Pressure
Yes No Kidney Disease
If yes, start date of dialysis:___________
Yes No Lupus
Yes No Migraine Headaches
Yes No Pacemaker
Yes No Rheumatic Fever
Yes No Shingles Where
Yes No Skin Conditions
Yes No Sleep Apnea
Yes No Stroke – If yes, date:__________
Yes No Thyroid Conditions

FAMILY HISTORY **RELATIONSHIP TO PATIENT**

Disease

Cataracts Yes No ______________________________
Diabetes Yes No ______________________________
Glaucoma Yes No ______________________________
Retinal
Detachment Yes No ______________________________
Macular
Degeneration Yes No ______________________________
Heart Disease Yes No ______________________________
Cancer
If yes, what type: Yes No ___________________________

PRIMARY CARE PHYSICIAN:

____
Address:_________________________
____
Phone #:_________________________
Eye Doctor:______________________

LIST ALL SURGERIES AND DATES:

____
____

DRUG ALLERGIES:

____

CURRENT MEDICATIONS:

MEDICINE	DOSE	FREQUENCY

OCULAR HISTORY: (eye surgeries/prev. problem)

____
____
____