John Niffenegger, MD
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Sarasota, FL 34233
(941) 924-0303
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Elizabeth Richter, MD, PhD
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Venice, FL 34285
(941) 412-0303
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(941) 924-0303
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Keye Wong, MD
3280 Tamiami Trail, Suite 41
Port Charlotte, FL 33952
(941) 743-3937
FAX (941) 623-0309

Dear Patient,

We would like to welcome you as a patient to Retina Associates of Sarasota. Your appointment will be scheduled with one of our doctors: Dr. John H. Niffenegger/ Dr. Keye L. Wong/ Dr. Beth Richter at your preferred location.

To expedite your visit please help us by completing the following forms and present these to the receptionist upon your arrival:

Patient Information Form

Patient Financial Form

Past Medical History and Review of Systems Form

HIPPA Compliance Notification Form

Please bring your insurance cards and photo identification. If you wear glasses bring your current pair.

Dr. Niffenegger/ Dr. Wong/ Dr. Richter will usually see you within one hour of your scheduled appointment and would prefer a family member be present (a driver) since your eyes will be dilated.

RETINA ASSOCIATES OF SARASOTA

PATIENT REGISTRATION FORM

PRIMARY CARE PHYSICIAN: _____ PREFERRED LANGUAGE: _____

REFERRING PHYSICIAN: _____ TRANSLATOR REQUIRED? YES__ NO__

PATIENT'S NAME_____
LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY NUMBER_____D.O.B._____ SEX_____ RACE_____

MARITAL STATUS_____CELL PHONE_____ ALTERNATE PHONE _____

EMAIL ADDRESS _____ IS IT OK TO LEAVE A MESSAGE ON THIS NUMBER? YES NO

PATIENT'S ADDRESS_____
STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS, IF DIFFERENT _____
MAILING / PO BOX CITY STATE ZIP

INSURANCE INFORMATION:
Primary:
INSURANCE NAME_____ POLICY # _____

GROUP #_____INSURED's EMPLOYER _____

POLICY HOLDER NAME _____ RELATIONSHIP to PATIENT

POLICY HOLDER DATE of BIRTH _____ POLICY HOLDER SS #

INSURANCE ADDRESS _____

Secondary:
INSURANCE NAME_____ POLICY # _____

GROUP #_____INSURED's EMPLOYER _____

POLICY HOLDER NAME _____ RELATIONSHIP to PATIENT

POLICY HOLDER DATE of BIRTH _____ POLICY HOLDER SS #

INSURANCE ADDRESS _____

EMERGENCY CONTACT INFORMATION:

NAME_____ PHONE _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

RETINA
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Patient Authorization to Release and/or Receive Information for the Purpose of Claim Payment

I hereby authorize Retina Associates of Sarasota, RAS physicians, and/or any RAS employees or agents to release any information regarding services rendered and allow a photocopy of signature to be used to collected for services and file claims to my insurance company. I hereby give permission to contact any party listed on this form in my medical chart to verify insurance, credit, or personal information. We want you to know that our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to always take reasonable precautions to protect your privacy and want you to know that we support your full access to your personal medical record. I understand that I am responsible for my health insurance co-payments, deductibles, co-insurance, and any non-covered services at the time services are rendered.

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Date

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Witness

<u>Lifetime Authorization</u>

Medicare and Medicaid Patient Certification-Authorization to Release Information and Payment Request

I certify that the information given by me in applying for payment under the TITLE XVII, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Date

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Witness

Consent for Communication

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I consent to receive text from the practice at my cell phone and any number forwarded to transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Date

_____ _____

Patient Signature (Guardian signature if Patient is a Minor) Witness

RETINA
ASSOCIATES OF SARASOTA

Pupil Dilation
Information and Consent

A portion of the complete eye examination which is performed in our office includes pupil dilation. This is essential for evaluation of your retinal condition. Pupillary dilation requires the placement of eyedrops which may last several hours. Dilation creates difficulty focusing on near objects or reading material. Dilation may cause driving an automobile or operating heavy machinery to be dangerous. Dilation of the pupils may rarely cause acute glaucoma. Signs include redness, severe pain, nausea, or loss of vision. If this occurs after dilation, please call our office immediately. By signing below, I understand the above and give my consent for pupil dilation during my visits to this office.

_____ _____
Patient Signature Date

Financial Agreement and Endorsement Authorization

The fee for service is an obligation of the patient and is due at the time of service. If you have medical insurance, our staff will assist you in obtaining the full allowable benefits from your insurance company. However, in the event the insurance company refuses previously confirmed coverage or reimburses a lesser amount than charged, the patient is fully responsible for the entire obligation. Any service not covered by your insurance company must be paid at the time of service.

I fully understand that I am directly and fully responsible to Retina Associates of Sarasota (RAS) for all medical bills submitted by RAS, or its agents, for services rendered to me. I further agree to allow Retina Associates of Sarasota to release any information necessary to process any medical claims rendered on my behalf. I further authorize payment of medical benefits to Retina Associates of Sarasota for services rendered. I have read the above and fully understand its contents and all of questions have been answered. I hereby agree to render payments in accordance with the terms and conditions set forth, and agree to collection fees, interest, court and attorney fees in order to collect any outstanding balances.

I (we) the undersigned, hereby authorize Retina Associates of Sarasota and its agents to endorse by (our) name, any medical drafts received from third payers.

_____ _____
Patient Signature (Guardian signature if Patient is a Minor) Date

_____ _____
Patient Signature (Guardian signature if Patient is a Minor) Witness

RETINA ASSOCIATES OF SARASOTA

HIPPA Notice of 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.

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 that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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 your 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 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 home health an agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure 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, obtained approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 students that see patients at our office. 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 your 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 heath information in the following situations without tour authorization. These situations include as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral 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.

Others 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.

RETINA
ASSOCIATES OF SARASOTA

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 purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as describes in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you request. If 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 request 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 may 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 any such rebuttal.

You may have the right to receive an accounting of certain disclosure 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 complain to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact to 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 in person or by phone at our Main Phone Number.,

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____	_____	_____
Print Name	Patient Signature	Date

RETINA ASSOCIATES OF SARASOTA

Patient Authorization for use and Disclosures of Protected Health Information to Third Parties

Retina Associates of Sarasota
Name of Practice

Section must be completed for all authorizations.

I hereby authorize the use of disclosure of my individually protected heath information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan of health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

ID Number: _____

Persons/Organizations receiving information:

Name	Relationship	Phone Number

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____/ _____/_____ (MM/DD/YYYY)
   Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have any effect on any actions they took before they received the revocation.
   Initials: _____

_____ _____
Signature of patient or representative
(Form MUST be completed before signing)
Date

_____ _____
Printed name of patient's representative
Relationship to patient

You may refuse to sign this authorization.