MEDICAL AND EYE HISTORY

Please fill out the information below completely regarding your medical information.

	YES	NO
Diabetes? HgA1c = ____	☐	☐
High blood pressure?	☐	☐
Chest pain?	☐	☐
History of heart disease?	☐	☐
Swollen legs/ankles?	☐	☐
Shortness of breath?	☐	☐
Asthma or emphysema?	☐	☐
Abdominal pain?	☐	☐
Nausea/vomiting?	☐	☐
Diarrhea?	☐	☐
Currently pregnant?	☐	☐
Blood in urine?	☐	☐
Oral or genital sores?	☐	☐
Fever?	☐	☐
Recent weight change?	☐	☐
Rashes or changed skin color?	☐	☐
History of thyroid disease?	☐	☐
Headaches?	☐	☐
Seizures?	☐	☐
Hearing loss?	☐	☐
History of stroke or TIA?	☐	☐
Numbness/weakness?	☐	☐
Joint pain?	☐	☐
Back pain?	☐	☐
Jaw pain?	☐	☐
Scalp tenderness?	☐	☐
Anemia?	☐	☐
Bleeding or clotting problems?	☐	☐
Swollen glands in neck?	☐	☐
History of HIV?	☐	☐
History of cancer?	☐	☐
Which? _____		
Depression?	☐	☐
Anxiety?	☐	☐
Other disease? _____	☐	☐
	YES	NO

Eye or head injury?	☐	☐
Glaucoma?	☐	☐
History of macular degeneration?	☐	☐
History of retinal detachment?	☐	☐
Myopia?	☐	☐
Double vision?	☐	☐
Eye surgery? _____	☐	☐
Family member with:		
Macular degeneration?	☐	☐
Retinal detachment?	☐	☐
Other eye disease? _____	☐	☐
History of drug abuse?	☐	☐
≥ 7 drinks/week of alcohol?	☐	☐
Do you smoke? In the past?	☐	☐

Occupation? _____

★Medication Allergies: _____ ☐None

Medications and Dose (including eye drops):
~Please list on the back of form if necessary~

_____

_____

_____

_____

Surgeries/Hospitalizations (please include year):

_____

_____

_____

_____

PATIENT INFORMATION

First name: _____ Middle Initial: _____ Last name: _____

Soc. Sec. #: _____ Date of Birth: _____ Gender: _____

Local Address: _____

City: _____ State: **Florida** Zip Code: _____

Out of Town Address: _____

City: _____ State: _____ Zip Code: _____

Home phone #: _____ Cell phone #: _____

Email address: _____

☐ Venice Retina has my permission to leave a message on my voicemail.

☐ Venice Retina has my permission to speak to _____ about my care and diagnosis.

Referring Physician: _____

Primary Care Physician: _____

Primary Insurance: _____ Member ID/Group#: _____

Insured's Name: _____ DOB: _____

Secondary Insurance: _____ Member ID/Group#: _____

Insured's Name: _____ DOB: _____

Consent for Medical Treatment & Payment Conditions

1) CONSENT FOR MEDICAL TREATMENT
I hereby consent to any and all (including emergency) treatment and services, diagnostic procedures, tests, and medical treatment required for the diagnosis of any illness or treatments by the physicians or his designee, medical staff and other agents, and/or employees of Venice Retina, P.A. Additionally, I consent to the use of my non-identifiable medical data and non-identifiable photographs for educational purposes. I acknowledge that no guarantees have been made to me as to the results of test, examination, treatments, procedures or any other services rendered.

Additional Provision for Minors/Incapacitated Patient: I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient or otherwise have authority to act on their behalf for health care decisions.

2) RELEASE OF MEDICAL INFORMATION (Third-Party Payers, Guarantors, Physicians)
By signing this form, I hereby authorize Venice Retina, P.A. to use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the health care operations of the provider treating me; including to a hospital, physician or other provider, guarantor of my accounts, or third-party payers for which I have assigned benefits for my treatment and care, and if requested, to my referring physician, or any other healthcare provider responsible for my care, and as otherwise provided in the Venice Retina, P.A. Notice of Privacy Practices. This includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS, ARC, or HIV diagnosis, testing and/or treatment for this period of illness. It also includes other admissions if related to the accident or illness giving rise to this visit, medical, and other information as necessary for the operations of Venice Retina, P.A., or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare and/or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carries for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. I further authorize the Department of Health and Human Services and/or Social Security Administration to release any confidential case information related to my application for government assistance requested by Venice Retina, P.A.

3) RELEASE OF LIABILITY FOR LOSS OF PERSONAL PROPERTY
I have been advised that it is in my best interest to keep my valuables at home. Accordingly, I hereby release Venice Retina, P.A. and the facilities in which services are rendered, from liability resulting from the loss by theft or negligence of any employee of the practice or of any third party. I agree that I am responsible for any item(s) I keep with me in my possession including, but not limited to, money, clothing, eyeglasses, jewelry, dentures, or any other personal items.

4) ASSIGNMENT OF BENEFITS
In executing the assignments of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay Venice Retina, P.A. directly for the services that Venice Retina, P.A. provided during this visit. In return for the services rendered and to be rendered by Venice Retina, P.A., I hereby irrevocably assign and transfer to Venice Retina, P.A., all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans for which I am entitled services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this visit, as furthered described under Section 2. This assignment shall be for the purpose of granting Venice Retina, P.A. an independent right of recovery against my insurer or health benefits plan, but shall not be construed as an obligation of Venice Retina, P.A. to pursue any such right of recovery. In no events will Venice Retina, P.A. retain benefits in excess of the amount owed to Venice Retina, P.A. for the care and treatment rendered during the admission. If a third-party payer (such as an insurance company or employer group or trust-sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist Venice Retina, P.A. in collecting payment from any such third-party payer. I hereby appoint Venice Retina, P.A. as my authorized representative to pursue, if it so choose, all administrative remedies, clams and/or lawsuits on my behalf and, at the election of Venice Retina, P.A., against any responsible third party, medical insurer, or employer-sponsored medical benefits plan for purposes of collecting any and all benefits due me for the payment of the charges referred to in Section 2 above. If Venice Retina, P.A. elects to pursue a claim or lawsuit against a third-party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing Venice Retina, P.A., to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing Venice Retina, P.A., to bring suit against the third-party payer in my name. I agree to pay over to Venice Retina, P.A. immediately all sums recovered in any claims or lawsuit brought on my behalf by Venice Retina, P.A. (up to the amount of the charges from Venice Retina, P.A, plus expenses and attorney's fees).

Initial: _____

5) MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT
I certify that if I am a Medicare or Medicaid patient the information given by me and applied under TITLE XVIII of the Social Security Act or TITLE XIX (Medicaid) is correct. I further authorize Venice Retina, P.A. or its employees to release to Social Security Administration or State of Florida, or its intermediaries any and all information needed to process this or any other Medicare-related claim. I request and assign that payment of all authorized benefits be made on my behalf to Venice Retina, P.A. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles, and co-insurance payments. In addition, subsequent rejection of Medicare and/or Medicaid claims, as a result of enrollment in an HMO, will constitute responsibility for payment on my part.

6) HMO/PPO/MEDIPASS MANAGED CARE PARTICIPATION
I understand that if I am a member of an HMO/PPO/MEDIPASS or other Managed Care Organization, I am responsible for obtaining the required authorization and referrals as mandated by my Managed Care Organization to receive care from this facility and its providers. *I further acknowledge that if I choose to receive services at this facility without proper authorization from my Managed Care Organization, I will be fully responsible for payment of my bill.* I realize that it is my responsibility as the patient to know whether a services, procedure, and/or test, etc. is covered by my Managed Care Organization. (As the patient, I may contact my Managed Care Organization to appeal their decision not to authorize services.)

7) GUARANTOR AGREEMENT
By signing as Patient/Parent/Guardian or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this visit or service, not covered by any insurance, program, sponsorship, or other third-party coverage I may have are due and payable by me at the time of the visit or service. I hereby acknowledge that Venice Retina, P.A. has agreed to bill my insurance or other third-party carrier and has agreed to do so as a courtesy, and Venice Retina, P.A. has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I may be billed by Venice Retina, P.A.

8) FAILURE TO FOLLOW PHYSICIAN'S ORDERS
I, as the patient, am expected to comply with a physician's orders to manage medical disease and/or symptoms. In the event that I do not follow physician's orders, the physician shall be released from any injury or illness claim resulting from my failure to follow orders, and I may be discharged from the clinic. Not following physician orders includes, but is not limited to, missing follow-up appointments, as well as missing or postponing or refusing additional tests or treatments which may rule out/confirm/discover/treat illness.

9) MISSED APPOINTMENTS
I am expected to notify Venice Retina, P.A. at least two days in advance of the need to cancel or reschedule an appointment. Two missed appointments within a 6-month period without the above notification may incur a warning letter, followed by dismissal from the practice for a third violation.

By signing below, I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein, which I agree shall be applicable to any and all care and treatment provided by Venice Retina, P.A. within one (1) year from the date signed. Furthermore, I acknowledge that I have been given the opportunity to read and ask questions about the information contained in this form, and that I either have no questions or that my questions have been answered to my satisfaction.

Signature: _____ Today's Date: _____

Patient Name: _____ Date of Birth: _____

VENICE RETINA

Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. Venice Retina, P.A. is dedicated to protecting the privacy of your health information. Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used, helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others. We are required by law to maintain the confidentiality of your health information in keeping with the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Venice Retina, P.A. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims payment or coordination of benefits and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records. There may be some services provided in our organization through contracts with Business Associates. Examples include, but are not limited to, laboratory tests, compilation of photographic slides, and patient satisfaction surveys. When these services are contracted, we may disclose some or all of your protected health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, we require the Business Associate to appropriately safeguard your information.

Venice Retina, P.A. is permitted or required to use or disclose protected health information without written consent or authorization in certain circumstances. Examples of such include, but are not limited to, public health requirements or court orders, appointment reminders or information regarding treatment alternatives or other
health-related benefits and services that may be of interest to the individual. Venice Retina, P.A. will not make any other use or disclosure of a patients protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written. Unless otherwise required by law your health record is the physical property of Venice Retina, P.A., however, the information belongs to you. Patients have the following rights with respect to their protected health information that may be exercised.

Individuals have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information by making a request at our office;
- Request an electronic copy of your health record at the costs of labor incurred in producing the electronic copy;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - o Was not created by us, unless the person or entity that created the information is no longer

available to make the amendment;

    - o Is not part of the health information kept by or for the office;
    - o Is not part of the information that you would be permitted to inspect or copy; or,
    - o Is accurate and complete.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Dr. Anita Shane at 941-202-1900.

Venice Retina, P.A. will abide by the terms of this notice or the notice currently in effect at the time of the disclosure. Venice Retina, P.A. also reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices. Venice Retina, P.A. will provide each patient with a copy of any revisions of its Notice of Privacy Practices at the time of their next visit or at their last known address if there is a need to disclose any protected health information of the patient. Venice Retina, P.A. will post the most current version of our notice on our website.

Any person may file a complaint to the practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: 602 S. MacDill Avenue, Tampa, FL 33609, 813-875-6373.

All complaints will be addressed immediately. No retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual noncompliance of the privacy standards. For further information, please contact Dr. Anita Shane at 941-351-1200.

Notice effective October 1st, 2012

I have read and received a copy of the Notice of Privacy Practices set forth by Venice Retina, P.A., and I understand and agree to the policies described in that document.

Signature: _____ Today's Date: _____

Patient Name: _____ Date of Birth: _____

VENICE RETINA

Financial Policy

Venice Retina, P.A. is dedicated to providing patients with high quality eye health care. Our financial policy describes the mandatory procedures regarding payment for our services. Please read and agree to this financial policy by prior to any treatment. *If you are unable to abide by this policy, your appointment may be rescheduled or cancelled.*

You, the patient, are responsible for ensuring that we have your most current insurance information. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

Patients with participating health insurance plans:

- If you provide us with your complete and accurate health insurance information, we will file your insurance claim as a courtesy to you.
- Co-pays, cost-shares, deductibles, and patients balances are due at the time of appointment check-in. We accept cash, check, or credit card.
    - A $35 fee will be charged for checks returned by the bank for insufficient funds.
- We may require that you contact your insurance company when payment is not made within a reasonable period; you are ultimately responsible for fulfilling payment for care.
- If full payment from your insurance company is not received within 45 days, we will hold you responsible for the remaining balance.
- You will be fully responsible for payment of any services not covered by your insurance.
- We will fully refund any overpayment to you.
- If an authorization/referral is required by your insurance at the time of service, please provide this to us upon check-in. If you are unable to provide this, we will ask you to reschedule your appointment or pay in full for your visit at the time of service.

Patients without participating health insurance plans (or patients without health insurance):

- You, the patient, are responsible to get confirmation from your insurance carrier that Venice Retina physicians are participating providers in your health plan. The patient will be responsible for any additional out of pocket expense if your insurance carrier determines that the doctor is out of network.
- Payment in full is due on the day of service for office visits and in-office procedures.
- Payment in full is due on the day before surgery for non-emergency cases.

Medical Records:

- Records requests for over 5 pages will be charged at a rate of 25 cents per page.
- Medical clearance forms, such as disability, back-to-work, and driver's license forms will incur an annual fee of $10/page above 4 pages.

By signing our financial policy consent, you give express permission to Venice Retina and its Affiliates or contractors to contact me at the current or any future numbers that are provided for my landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or test messages.

If you have any questions regarding our financial policy, please contact us at (941) 202-1900.

I have read and understood the above Financial Policy from Venice Retina, P.A., and agree to abide by all aspects of this agreement.

Signature: _____ Today's Date: _____

Patient Name: _____ Date of Birth: _____

VENICE RETINA