RETINA NORTHWEST, P.C.

PATIENT REGISTRATION FORM

_____
APPOINTMENT DATE

PATIENT INFORMATION:

Name _____
Last First M.I. Sex

Address _____
Street Address City State Zip

Phone #: Home (____) _____ Work (____) _____ Cell (____) _____
Area Code Area Code Area Code

Birthday ____/____/_____ Age _____ years Social Security # _____

Marital Status (select one): ☐ Single ☐ Married ☐ Widowed

Work Status (check all that apply):
_____ Working: Full Time
_____ Working: Part Time
_____ Not Employed
_____ Retired
_____ Student: Full Time
_____ Student: Part Time

If working, please provide the following:
Occupation _____

Employer _____

Work Phone # (____) _____
Area Code

EMERGENCY CONTACT INFORMATION: _____ Phone: (____) _____
(NAME & RELATIONSHIP) Area Code

PRIMARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth ____/____/_____ Subscriber's Sex _____

Relationship to Patient _____ Subscriber's Employer _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth ____/____/_____ Subscriber's Sex _____

Relationship to Patient _____ Subscriber's Employer _____

ACCIDENT OR INJURY INFORMATION: Is this visit a result of an accident or injury?: Yes____ No____

Date of Accident or Injury ____/____/_____ Type (select one) ☐ Work ☐ Auto ☐ Other _____

If work related: Employer at time of injury _____ Phone# _____ Claim # _____

Which Doctor Referred You to Retina Northwest?	Who is Your Primary Care Physician?
_____ ☐ First and Last Name	_____ ☐ First and Last Name
_____ Address City State Zip	_____ Address City State Zip
Phone# (_____) _____ Area Code	Phone# (_____) _____ Area Code

Retina Northwest, P.C.

www.retinanorthwest.com

RETINA & VITREOUS DISEASES

Physicians and Surgeons

Please help us with your evaluation by providing detailed information. Thank You.

Your Name: Title: Today's Date:

Date and Place of Birth: Age: Male/Female:

Your family doctor (primary care provider): Date of last exam:

Your general eye doctor: Date of last exam:

Do you wear a vision correction? □ No □ Glasses □ Contact Lenses

□ Full time □ For certain tasks only

□ Monovision (one eye for distance and the other for near work)

Date of current prescription:

How old were you when you began to wear glasses?

What changes in your vision led you to see an eye doctor recently?

What do you believe might be causing the problem?

Is your Eye problem related to an injury? □ No (skip to next section)

□ At Work □ Motor Vehicle Accident □ Other

Describe the events leading to the injury: Date: Time: Place:

Please list any eyedrops, medicines and supplements that you take *for your eyes*: □ None

Right Eye				Left Eye		
Name	How often	For:		Name	How often	For:

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ State: _____

Have you had any of the following?
Please check yes or no, and add details such as duration, and the name of any specialist treating you.

Yes	No	Description	Notes
☐	☐	Cataract	
☐	☐	Glaucoma	
☐	☐	Aging Macular Degeneration	
☐	☐	Visual Migraine	
☐	☐	Injury to your eyes or face	
☐	☐	Lazy Eye	
☐	☐	Retinal Disease	

Do you have any of these symptoms? ☐ No (skip to next section)

Description	No	Right Eye	Left Eye	Notes: Severity? Duration?
No Vision Change				
Distortion (bent out of shape)				
Blurring				
Dimness				
Blind Spot or Area				
Flashes or Flickering				
Floaters				
Eyestrain				
Dry or burning eyes				
Severe light sensitivity				
Headache				
Tearing				
Other				

Please list all previous surgery, laser or prolonged drug treatment for your eyes:	□ None
Date	Describe which eye, who was the surgeon, and reason for the procedure

Personal History

Your Occupation: _____ (□ Retired)

Do you have particular visual needs for hobbies or work?

How much do you drive? □ None □ Local area only □ Everywhere □ for Work □ CDL

Do you live: □ Alone □ In Assisted Care □ With Family / Friends

Do you drink any alcohol? □ None □ up to 2 drinks daily □ More

Do you smoke tobacco? □ Never □ None since_____ How much in the past?_____

□ Yes How much currently?_____

Have you used any recreational drugs recently? □ Never □ Yes_____

Race? (Federal Statistics and Administration reporting for medical purposes)

□ I Decline to Answer □ American Indian or Alaska Native □ Asian □ Other

□ Native Hawaiian or Pacific Islander □ White □ Black or African American

Ethnicity? (Federal Statistics and Administration reporting for medical purposes)

□ I Decline to Answer □ Hispanic or Latino □ Not Hispanic

Preferred Language? _____ □ Interpreter Needed

Self Reported Blood Pressure, Weight, Height? (Federal Statistics and Administration reporting for medical purposes)

BP: _____/_____mmHg Weight: _____lbs Height: _____inches

Patient Initials_____

Your General Health

Please list your medicines and supplements, and the condition that you take them for:			□ None		
Name	Dose	For:	Name	Dose	For:

Please list any Allergic reactions you have to medications, food etc.	□ None
Name	Reaction

Please list any major operations, hospitalizations, injuries or illnesses:	□ None
Date	Event

Do you have Diabetes? □ No (skip to next section) □ Pre-diabetes □ borderline blood sugar

□ Yes Date of onset _____

Have you had side effects? □ Skin ulcers □ Kidney problems □ Peripheral neuropathy

Treatment □ Diet □ Oral meds □ Insulin

How often do you check your blood sugar? □ Rarely ____times daily

What are your readings in the past month? Lowest _____ Highest ____ Average ____

Do you know a recent Hemoglobin A1c result? _____% Date _____

REVIEW OF SYSTEMS		
No	**Yes**	**Have you experienced any of these symptoms recently?**
		Constitutional
		NIGHTS SWEATS
		CHILLS or FEVER
		UNUSUAL FATIGUE
		HEENT
		DIFFICULTY HEARING CONVERSATION (HEARING LOSS)
		Respiratory
		COUGH
		WHEEZING or ASTHMA
		Cardiovascular
		RACING or FLUTTERING HEART BEAT
		CHEST TIGHTNESS or PAIN
		Gastrointestinal
		CONSTIPATION
		NAUSEA or VOMITING
		CHANGE IN STOOLS (DIARRHEA)
		Genitourinary
		PAIN or BURNING on Urination (DYSURIA)
		BLOOD IN URINE (HEMATURIA)
		Metabolic/Endocrine
		COLD INTOLTERENCE
		HEAT INTOLERANCE
		INCREASED THIRST (POLYDIPSIA)
		INCREASED APPETTITE (POLYPHAGIA)
		FREQUENT UNRINATION (POLYURIA)
		Neurological
		DIZZINESS or LOSS OF BALANCE
		TROUBLE WALKING (GAIT DISTURBANCE)
		FREQUENT HEADACHE
		Psychiatric
		EMOTIONAL CHANGES
		Integumentary
		ITCHING, RASH, or HIVES
		Musculoskeletal
		SWOLLEN, PAINFUL, or STIFF JOINTS (ARTHRALHIAS)
		MUSCLE WEAKNESS
		Hemotalogic
		EASY BRUISING
		PROLONGED or SPONTANEOUS BLEEDING
		Immunologic
		ENVIRONMENTAL ALLERGIES
		FOOD ALLERGIES

Have you had any of the following?

Please check yes or no, and add details such as duration, and the name of any specialist treating you.

Yes	No	Description	Notes
☐	☐	High Blood Pressure	
☐	☐	Heart Disease	
☐	☐	Asthma, or COPD	
☐	☐	Sleep Apnea	
☐	☐	Home Oxygen therapy	
☐	☐	Tuberculosis	
☐	☐	Stroke	
☐	☐	Seizure Disorder	
☐	☐	Kidney Disease, Failure, or Dialysis	
☐	☐	Hepatitis	
☐	☐	Thyroid Disorder	
☐	☐	Anemia, or blood disorder	
☐	☐	Treatment to thin your blood	
☐	☐	Sexually transmitted disease	
☐	☐	Cancer	
☐	☐	Chemotherapy or Radiation Therapy	
☐	☐	Arthritis	
☐	☐	Stomach ulcers. Colitis	
☐	☐	Blood Transfusion	
☐	☐	Immune System Disorder	
☐	☐	Other	

Family History

Please indicate if these illnesses occurred amongst your relatives: ☐ No information available							
Description	No-one	Grand Parents	Father	Mother	Sister	Brother	Children
Retinal detachment							
Retinal Disease							
Macular Degeneration							
Blindness							
Glaucoma							
Cataract							
Eye Tumor							
High Blood Pressure							
Heart Disease							
Diabetes							
Cancer							
Migraine							
Other							

I have answered these questions as completely as possible.

Signature: Date:

****

If you have completed this form on behalf of the patient, please write in your name and relationship to the patient:

_____

RETINA NORTHWEST, PC
PAYMENT POLICY

Effective Date: February 23, 2012

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy towards that end.

All accounts are due and payable within 30 days unless special arrangements are made with our Business Office.

We are willing to bill your insurance when you provide us with current information and necessary forms. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim after 60 days, or for negotiating a disputed claim. *You are responsible for payment of your account.*

If you are without insurance coverage, please contact the Business Office now to make payment arrangements.

Your signature below will acknowledge that you have read and understand our credit policy. Specifically:

> I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be assigned to a credit reporting and collection service. If it becomes necessary to effect collections of any amount owed for care received today or subsequent to today, I agree to pay for all collection costs and expenses incurred, including reasonable attorney fees.
>
> Also, by my signature below I authorize payment of medical benefits otherwise payable to me to be made directly to Retina Northwest, PC. I hereby authorize Retina Northwest, PC to furnish my insurance carrier(s) with all information for which said insurance carrier may have cause to request concerning my claims. I understand that I am financially responsible for charges not covered by my insurance.

_____ _____

Patient or Guarantor Signature Date

RETINA NORTHWEST P.C.
NOTICE OF PRIVACY PRACTICES
Effective Date: September 23, 2013

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 is your Health Information Privacy Notice from Retina Northwest (RNW). This notice describes how we protect the personal health information we have about you and how we may use and disclose this information.

Protected health information **("PHI")** is health information that contains identifiers, such as your name, social security number or other information that reveals who you are. It may be in the form of written or electronic records or spoken words.

We are required by law to give you this notice. It will tell you about:

1. The ways in which we may use and disclose health information about you;
2. The situations in which we are required to obtain written authorization from you to release personal health information; and
3. Your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Your confidentiality is important to us. We have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We describe these uses and disclosures below. How much PHI is used or disclosed depends on the intended purpose of the use or disclosure. In some cases, only a limited amount is disclosed, such as when we call to remind you of your appointment with us. At other times, we may need to use or disclose more PHI, such as when we are coordinating your health care with another physician.

Treatment. We may use PHI to provide you with medical treatment or services. We may disclose PHI to our staff of doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. We may disclose PHI to health care providers who are not on our staff. We may disclose PHI to family members who may be part of your medical care outside this office and may require information to provide that care.

For example, if you are being treated for macular degeneration, we may share your PHI with your primary physician, your ophthalmologist, and a family member that is assisting you in coordinating your care.

Payment. We may use and disclose PHI to obtain payment for services we, or other providers who are coordinating your care, provide for you. We may disclose PHI to other organizations and providers for payment activities unless disclosure is prohibited by law.

For example, we disclose PHI when billing and collecting payment from your health insurance company. We also tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your plan will pay for the treatments.

Health Care Operations. We may use and disclose PHI in relation to health care operations. We may disclose PHI to administer and support our business activities or the business activities of other health care organizations, such as your insurance plan.

For example, PHI may be used for quality assessment and improvement, training and evaluation of staff, licensing, and accreditation.

Business Associates. We may disclose PHI to other individuals and organizations that help us with our business activities. If we share your PHI for this purpose, the individuals and organizations must agree to protect your privacy.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office. These reminders may be made by postcard, phone, e-mail, or voicemail.

Treatment Alternatives and Services. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may tell you about health related products or services that may be of interest to you.

Legal and Governmental Purposes: We may use and disclose PHI in the following circumstances:

Required by law. We may disclose PHI when we are required to do so by state and federal law.

Public Health and Safety. We may disclose PHI to an authorized public health authority. Public health activities include many functions needed to promote and protect public health and safety, including the prevention or control of disease, injury, or disability, the reporting of vital statistics and the investigation or tracking of problems with prescription drugs and medical devices.

Abuse and Neglect. We may disclose PHI to government entities authorized to receive reports regarding abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose PHI to health oversight agencies for certain activities such as audits, examinations, investigations, inspections and licensures.

Legal proceedings. We may disclose PHI in responding to an order of a court or administrative agency, and in certain cases, in response to a subpoena, discovery request, or other lawful process. We may also use and disclose PHI to the extent permitted by law without your authorization in defending a lawsuit or arbitration.

Law enforcement. We may disclose PHI to authorized officials for law enforcement purposes. For example, we may use or disclose PHI to report a crime on our premises or help identify or locate someone.

Military activity, national security, Protective Services for the President and Others. We may release PHI if required by military command or other government authorities.

Coroners, funeral directors. We may disclose PHI to a coroner or funeral director.

Inmates. Inmates do not have the same rights to control their PHI as other individuals. We may disclose your PHI to the correctional institution or the law enforcement official for certain purposes such as, for example, to protect your health or safety or someone else's.

Other Special Circumstances: We may use and disclose PHI under the following circumstances:

Communication with family and others when you are present. We may use and disclose PHI to a member of your family, a relative, a close friend, or any other person who is directly involved in your health care. If you object, please tell us and we won't discuss your PHI or we will ask the other person to leave.

Communication with family and others when you are not present. We may use and disclose PHI about you

when you are not present or are unable to make a health care decision for yourself. In these instances, we will use our professional judgment to determine that disclosure is in your best interest.

For example, we may disclose PHI to the person who is waiting for you at the hospital during an outpatient procedure.

Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ and tissue procurement and transplantation.

Research. RNW participates in important health research. Some of our research may involve medical procedures and some is limited to collection and analysis of health data. Your PHI can generally be used or disclosed for research without your permission if an Institutional Review Board (IRB) approves such use or disclosure. If you are involved in research involving a medical procedure, we will inform you prior to participation of your privacy rights.

Serious Threat to Health or Safety. We may use and disclose your PHI if we believe it is necessary to avoid a serious threat to your health or safety or to someone else's.

Marketing. RNW may use and disclose your PHI to contact you about benefits, services or supplies that we can offer you related to your health care at RNW.

WRITTEN AUTHORIZATIONS TO RELEASE PERSONAL HEALTH INFORMATION

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us Authorization to use or disclose PHI, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If you would like to ask us to disclose your PHI, please contact the Medical Records & Privacy Department at 503-274-2121 for an authorization form.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You may exercise any of the rights described below, or ask questions about these rights by contacting the Medical Records and Privacy Office at 503-274-2121. We will provide you a copy of the forms needed for submission of your written requests.

You have the following rights regarding health information we maintain about you:

Right to See and Receive Copies. You have the right to see and receive copies of your health information, such as medical and billing records. Requests must be in writing and we may charge a reasonable fee for the cost of producing and mailing copies.

We may deny your request in certain limited circumstances. We will tell you why we are denying your request. In some cases, you may request that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Request an Amendment. If you believe health information we have about you is incorrect or incomplete, you may ask that we correct or add to the record.

Your request for an amendment must be in writing and must provide the reasons for your request. We will respond in writing after receiving your request. In certain cases we may deny your request. You may respond by filing a

written statement of disagreement with us and ask that the statement be included with your PHI.

Right to an Accounting of Disclosures. You have the right to request, in writing, an "accounting of disclosures." This is a list of the disclosures of your PHI for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization. We may charge you a reasonable fee if you request more than one accounting of disclosure per year.

To obtain this list, you must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free of charge.

Right to Request Restrictions. You have the right to request, in writing, a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

Right to Request Alternate Means of Communication. You have the right to request that we communicate with you about medical matters at a different address or by a different means. For example, you can ask that we only contact you at work or only by mail. We will agree to reasonable requests. However, we are permitted to charge you for any additional cost of sending your PHI or contacting you via these alternate ways.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice upon request.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If we change any of the practices described in this Notice, we will post the revised Notice in our medical offices.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated or you disagree with a decision we made about access to your health information, you may file a written complaint with:

Retina Northwest Privacy Officer
2525 NW Lovejoy St. #100
Portland, OR 97210.

For more information on how to file a written complaint, call the Privacy Officer at 503-274-2121. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized if you file a complaint about our privacy practices.

RETINA NORTHWEST, PC

PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I understand that Retina Northwest (RNW) will use and disclose health information about me.

I have received a copy of RNW's Notice of Privacy Practices, effective April 14, 2003. This notice describes how RNW and its physicians, employees, staff and other office personnel may use and disclose health information about me. It explains my rights with respect to my health information and how I can exercise these rights.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon my request.

By signing below, I agree that I have reviewed and understood the information and that I have received a copy of the Notice of Privacy Practices.

Signature: _____Date:_____

Description of Patient Representative's Authority (if not signed by patient)_____

Release of Information Authorization

Many patients have a spouse, relative(s) and/or friend(s) who helps with and is involved in their medical care. In order for us to share information about your care with these people, we need a release from you. Please list below those people with whom we can discuss your medical care, including your appointments, medical conditions, recommended treatments, and account payment arrangements.

Name	Birthday	Relationship	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____
Patient Signature Date

04/14/03
Revised 11/8/2007