RETINA CONSULTANTS OF NEVADA

PATIENT REFERRAL FORM

DATE _____ DOB _____

PATIENT NAME _____

PHONE (HOME) _____ CELL _____

INSURANCE COMPANY _____

INSURED PERSON _____

AUTHORIZATION NO. _____

AUTHORIZED BY _____

REFERRING DOCTOR _____

ADDRESS _____

_____

TELEPHONE _____

☐ **Referral for Retinal Consultation**

EXAM RESULTS

☐ PHONE ☐ LETTER ☐ FAX

DIAGNOSIS

☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Flashes/Floaters
☐ Retinal Detachment ☐ Retinal Tear ☐ Unexplained Vision Loss
☐ Other _____

AUTHORIZATION

I, _____ authorize release of all records pertaining to my care from my referring physician to Retina Consultants of Nevada.

YOUR APPOINTMENT

is on _____ with

☐ Dr. Parker ☐ Dr. Hollifield ☐ Dr. Liu ☐ Dr. Swati Agarwal-Sinha
☐ Dr. Wickens ☐ Dr. Loo ☐ Dr. Yepremyan ☐ Dr. Amar Mannina

PLEASE BRING FORM WITH YOU TO YOUR APPOINTMEN

(702) 369-0200
(800) 228-5810

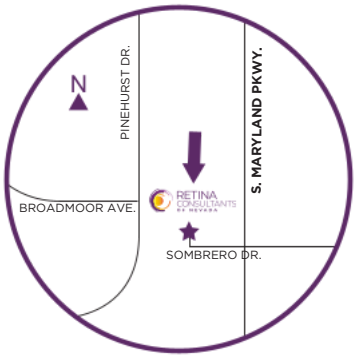
OUR LOCATIONS

SUMMERLIN OFFICE

(702) 369-4143 FAX
653 N. TOWN CENTER DR.
SUITE 518
LAS VEGAS, NV 89144

EAST SIDE OFFICE

(702) 951-6010 FAX
3201 S MARYLAND PARKWAY,
SUITE 500
LAS VEGAS, NV 89109

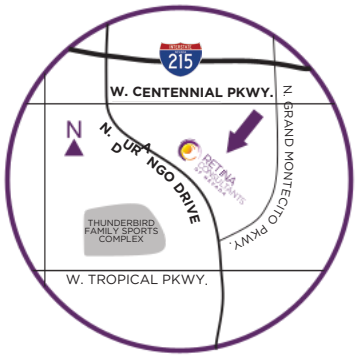


GREEN VALLEY OFFICE

(702) 851-9447 FAX
710 CORONADO CENTER DR.
SUITE 201
HENDERSON, NV 89052

CENTENNIAL OFFICE

(702) 405-6110 FAX
6220 N DURANGO DR.
LAS VEGAS, NV 89149



MESQUITE OFFICE

1301 BERTHA HOWE AVE
MESQUITE, NV 89027
(702) 369-0200

REMINDERS WHEN VISITING OUR OFFICE

- **Plan on being in our office 2 hours.**
- **Your eyes will be dilated.**
- **Arrange to have a driver.**
- **Bring a list of all medications.**
- **Bring all**

Insurance cards (Medicare card).

- **Bring glasses, contacts and contact case.**

PLEASE BRING FORM WITH YOU TO YOUR APPOINTMENT

(702) 369-0200
(800) 228-5810

PATIENT INFORMATION

PLEASE PRINT CLEARLY

ACCT# _____

2 3 8 10 11 12 14 15

E W GV SG Ln CH

Name _____ Date _____
First Last

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex ____ Age ____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security # _____ Date of Birth _____

Referred By _____ ☐ Yellow Pages ☐ Newspaper Ad ☐ Health Fair

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext. ____

Spouse's Name & Address _____ Home Phone _____

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext. ____

Spouse's Social Security # _____ Date of Birth _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician's Name _____

Address _____ Phone # _____

●PLEASE TURN OVER●

I WILL BE PAYING TODAY BY:
(CHECK ONE)

❒ CASH ❒ CHECK ❒ CREDIT CARD

❒ MEDICARE ❒ SILVER STATE ❒ SIERRA HEALTH

❒ PACIFICARE ❒ MEDICAID ❒ HPN

❒ OTHER INSURANCE _____

PLEASE READ CAREFULLY AND SIGN

I understand that every visit my eyes will be dilated. I understand that it is legal to drive dilated, but I may be more comfortable if I have a driver.

I understand that I am financially responsible for all charges incurred.

I request that payment of authorized insurance benefits be made to Retina Consultants of Nevada for any services furnished me.

A handling fee will be charged for personal checks returned from the bank for any reason.

This consent acknowledges and permits Retina Consultants of Nevada to use and disclose Protected Health Information (PHI) to carry out treatment, payment or healthcare operations.

_____ _____

Patient's Signature Date

MEDICAL INFORMATION

PATIENT'S NAME: _____ **DATE:** _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

MAJOR OPERATIONS: _____

CURRENT VISUAL COMPLAINTS: _____

HISTORY	PATIENT HISTORY YES	NO	COMMENTS	FAMILY HISTORY YES	NO	COMMENTS
CATARACTS						
GLAUCOMA						
CROSSED EYES						
LAZY EYE						
BLINDNESS						
RETINAL PROBLEMS						
EYE INJURY						
EYE SURGERY						
RECENT FLASHES/FLOATERS						
DISTORTION						
PERIPHERAL VISION LOSS						
DOUBLE VISION						
ARE ACTIVITIES IMPAIRED VISUALLY?						
DIABETES						
HIGH BLOOD PRESSURE						
HEART DISEASE						
STROKE						
VASCULAR DISEASE						
GASTROINTESTINAL						
KIDNEY/URINARY TRACT DISEASE						
NEUROLOGICAL						
EMPHYSEMA OR ASTHMA						
CANCER						
TUBERCULOSIS						
BLOOD TRANSFUSION						
OTHER MEDICAL CONDITIONS						
DRUG/ALCOHOL USE						
TOBACCO USE						

RETINA CONSULTANTS OF NEVADA

Authorization For Release of PHI From Other Source

I, _____, specifically authorize any current employee or owner of
(Please Print Your Name)

_____
Name(s) or Class of Person(s)

_____
Address, City, State, Zip

_____
Phone Number Fax Number

To release or disclose my protected health information ONLY to:

Retina Consultants of Nevada
653 N Town Center Drive - Suite 518
Las Vegas, NV 89144
702-369-0200
702-369-4143 (Fax)

Any disclosure of my protected health information to a **different** name, class of person, address or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization, or if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed or on the following date: _____. After one year or this date (which ever comes sooner), the above name(s) or class of person(s) can no longer use or disclose my protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient Signature **Date of Birth**

_____ _____
Social Security Number **Date of Request**

_____ _____
Request Processed By **Date**

_____ _____
Completed By **Date Mailed/Faxed (Circle One)**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MIGHT BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION….*PLEASE REVIEW IT CAREFULLY.*

Retina Consultants of Nevada is committed to treating and using your *Protected Health Information* (PHI) responsibly. As of April 14, 2003, the *Health Insurance Portability & Accountability Act* (HIPAA) requires us to:

1. Maintain the privacy of medical information provided to us
2. Prevent inappropriate use of that information
3. Provide notice of our legal duties and practices, and
4. Abide by the terms of our Notice of Privacy Practices currently in effect.
5. Protect and enhance patient rights by giving you, the patient, control of your medical information.

Understanding Your Protected Health Information (PHI)

Protected health information is an individual's healthcare information that is transmitted or maintained by a covered entity in any form (paper, electronic, or verbal).

You will be providing us with personal information such as, but not limited to:

1. Your name, address and phone number
2. Information relating to your medical history
3. Your insurance information and coverage
4. The name of your referring and/or primary care physician

Uses for *protected health information (PHI)*:

1. Basis for planning your care and treatment.
2. Legal document describing the care you received.
3. Means of communication among the many health professionals who contribute to your care.
4. Means by which you or your insurance company (payer) can verify that services billed were actually provided.
5. A source of data for our planning and marketing.
6. A source of information for public health officials charged with improving the health of this state and the nation.
7. A tool with which we can work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps ensure its accuracy and assists with informed decisions when authorizing disclosure to others.

Permitted uses and disclosures of protected health information (PHI):

Minimum Necessary: requires a covered entity (physician) to ensure that the work force reasonably minimizes the amount of protected information used, disclosed, and requested. It also limits who has access to such information.

Use: is the sharing, employment, application, utilization, or analysis of an individual's information within a covered entity that maintains such information.

Disclosure: is information, including demographic information collected from an individual, that

1. Is created or received by a health care provider, health plan, employer, or health care clearing house.
2. Relates to:
   a. the past, present, or future physical, mental health or condition of an individual;
   b. the provision of health care to an individual;
   c. the past, present, or future payment for the provision of health care to an individual;
   d. that which identifies the individual;
   e. for which there is a reasonable basis to believe the information can be used to identify the individual.

Retina Consultants of Nevada's *Health Team* consists of all office personnel, including Front Office, Transcription, Billing, Back Office, Administration and Physicians.

Disclosures for Treatment, Payment and Operations (TPO)

Disclosures include but are not limited to use of *protected health care information* for treatment, payment and health care operations.

Treatment*:* The provision, coordination or management of healthcare and related services and extends to consultation between providers or the referral of a patient from provider to provider.

1. Information obtained by a nurse, physician, or other member of our *healthcare team* will be recorded in your record and used to determine the course of treatment.
2. We will provide your referring physician and subsequent healthcare provider with reports needed to concur and assist in treatment.

Payment*:* A broad range of activities managing use of data on premiums, reimbursement, eligibility and coverage determinations, risk adjustment, billing and claims management coverage, and utilization review activities as well as disclosure to consumer reporting agencies of certain information.

1. We will use your *protected health information* to facilitate payment as mandated by your Third Party Payer for referrals, authorizations, and payment of a claim.

Operations*:* A covered physician's daily activities as they relate to the provision of health care.

1. We will use your *protected health information* to support regular healthcare operations.

Authentication: To ensure that we disclose *protected health information* to the appropriate patient or personal representative, we must verify said information by:

1. First and last name
2. Last four digits of social security number
3. Date of birth
4. Picture ID

Retina Consultants of Nevada will authenticate every patient or personal representative at *each* encounter or contact with our practice.

Communication: Physicians and healthcare team members, using their best judgment, may disclose to your personal representative health information relative to their involvement in your care or payment related issues.

Appointment Process:

A sign-in sheet will be used at every appointment.

Our *health care team* will verbally use your name to call you back and will continue to use your name throughout the visit.

Consent to Treat: The Patient Information Sheet requires a patient signature for consent to treat, financial responsibility, and authorization to bill your Third Party Payer.

Appropriate *consents* for testing, procedures, and surgery will be given to you the patient for review and signature.

Patient status during visit: We may use or disclose information about your general condition or location to your personal representative.

Transporting Records: All records are kept at our main office. If you are seen at a satellite office our designated healthcare team member will transport your record.

Faxing Records: Records may be faxed between our offices, referring and subsequent physicians, hospitals, pharmacies, or third party payers.

Special Situations

Public Health: We may disclose medical information about you to facilitate public health purposes. These generally include the following:

- Prevention or control of disease, injury or disability;
- Reporting of births and deaths;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may be using;
- Notifying a person who has been exposed;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease of condition.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

Abuse or Neglect Cases: We may disclose your *protected health information* to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your *protected health information* if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Protective Services for the President, National Security and Intelligence Activities: We may release information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Inmate: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your *protected health information* in the course of providing care to you.

Worker's Compensation: Your *protected health information* may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

Telephone Communication:

Telephone: We may call to remind you of your appointment and leave messages of your upcoming appointment on your answering machine *unless you tell us you object*.

Physicians at Retina Consultants of Nevada may call regarding test results. If unable to contact you, the patient, a message may be left on your answering machine, or with a family member or friend for a return phone call *unless you tell us you object*.

Mail: We may mail letters or postcards to remind you it is time for you to make another appointment *unless you tell us you object*.

Business Associates are outside entities that the practice may use in the treatment of our patients and payment of services. Business Associates examples may include but are not limited to hospitals, laboratories, radiologists, electronic-claims clearinghouses, collection agencies, attorneys, and insurance companies. To protect your *protected health information (PHI)*, we *require* the business associate to appropriately safeguard your information - *unless you tell us you object*.

Patients Protected Health Information (PHI) Rights

Although patient healthcare information is the physical property of Retina Consultants of Nevada, patients have the right to:

1. request restrictions on use and disclosure of *protected health information*.
2. receive confidential communications.
3. inspect and receive a copy of their *protected health information.*
4. amend or submit corrections to their *protected health information*.
5. receive an accounting of disclosures of *protected health information*.
6. revoke authorization to use and disclose health information, except to the extent that action has already been taken.
7. receive a paper copy of this notice.

A request for any of the above *protected health information,* must be done in writing.

Authorization for Release of PHI

If you object to having your *protected health information (PHI)* used in the manners described above, you must sign a form indicating your objection and you must indicate who is your authentic representative in case you are unavailable or unable to communicate with any of our *healthcare team*.

A *healthcare team* member cannot speak to any one but you the patient, unless otherwise authorized in writing by you the patient. We will authenticate the representative before speaking with that person.

You the patient or your personal representative may request in writing release of *protected health information* to a specific physician, insurance company, disability office (work or state), employer, etc. Your patient signature is required on each release of information requested. The release is valid on a one-time basis unless otherwise specified.

Responsibilities of Retina Consultants of Nevada

1. Maintain the privacy of your health information.
2. Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you when we are unable to abide by a requested restriction.
5. Accommodate reasonable requests. You may have to communicate health information by alternative means or at alternative locations.

We have the right to change our practice policies and make new revisions effective for all *protected health information* we maintain. Should our information policies or the Federal regulations change, a revised notice will be posted in our waiting room.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If there has been a violation of disclosure of *protected health information*, we will investigate and review circumstances, correct, continue to train staff, and try to improve policy practices within the office. In certain instances, disciplinary actions will be taken.

If you have any questions and would like more information, you may call 702-369-0200 and ask for the Privacy Officer.

If you believe your rights have been violated, you may file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. Retina Consultants of Nevada will not retaliate should you, the patient, decide to lodge a complaint with either the Privacy Officer or the Office of Civil Rights (OCR). The mailing address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Their e-mail address is ocrmail@hhs.gov.

Acknowledgment of Receipt of Privacy Notice

I, _____, hereby acknowledge that I have received a copy of this Privacy Notice.

Signature: Date:

RETINA CONSULTANTS OF NEVADA

Our Promise of Privacy and Consent To Patient Records

Our office is fully committed to compliance with HIPAA guidelines by:

- ❑ Providing appropriate **security** for our patient records.
- ❑ Protecting the **privacy** of our patient's medical information
- ❑ Providing our patients with proper **access** to their medical records.
- ❑ Appropriately maintaining our patient information and billing processes in compliance with national **standards**.

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Privacy Officer.

Compliance Assurance Notification For Our Patients

To Our Valued Patients:

The misuse of Protected Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of 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 achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of Protected Health Information (PHI) in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

RETINA CONSULTANTS OF NEVADA

Patient-Appointed Designate Authentication & Authorization Form

According to HIPAA and as our patient, you are entitled to privacy of your ***protected health information*** (**PHI**). We are required to offer you the option to appoint a person of your choice who Retina Consultants of Nevada may disclose your PHI to on your behalf. This designate would be someone who would accompany you to the office; someone who the Retina Consultants of Nevada's healthcare team may call to relate information about you to; someone who would call in for information regarding your care and treatment. You have the right to revoke or change your choice of designate in writing, except to the extent that action has already been taken in reliance on this authorization, or if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Retina Consultants of Nevada must receive the revocation in writing. Retina Consultants of Nevada will accept written revocation of this authorization to the Privacy Officer, via CERTIFIED MAIL; and said revocation will not be in effect until received by said Privacy Officer.

Patient Name: ____

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	______________________	____________	____________	________	____________

Patient Signature:______________________ Date: ____________

Revocation Effective: ______________
FOR OFFICE USE ONLY

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	______________________	____________	____________	________	____________

Patient Signature:______________________ Date: ____________

Revocation Effective: ______________
FOR OFFICE USE ONLY

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	______________________	____________	____________	________	____________

Patient Signature:______________________ Date: ____________

Revocation Effective: ______________
FOR OFFICE USE ONLY