RETINA SPECIALISTS

PATIENT INFORMATION FORM

Please print and provide complete information for each item.

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____ Age: _____ Sex: _____

Marital Status: _____ Social Security No.: _____ Driver License # _____

Have you been a patient before, under what name? _____

Do you live in a skilled nursing facility? ❑ Yes ❑ No

If yes, Facility Name: _____

Facility Address: _____

EMPLOYER INFORMATION:

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Occupation: _____

PARENT/SPOUSE:

Name: _____ Relationship: _____

Employer: _____

Employer's Address: _____ Telephone: _____

Social Security No.: _____ Date of Birth: _____

Other Contact (other than spouse): _____

Relationship: _____ Telephone: _____

Referred by: _____ **Family Physician:** _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Ins. Co. Phone: _____

Policy ID#: _____ Group #: _____

Name of Insured/Policyholder: _____ Date of Birth: _____

Relationship to Patient _____ Subscriber's SS#: _____

Is this insurance through an employer? ❑ Yes ❑ No If yes, please complete the following:

Employer's Name _____ Address: _____

City, State, Zip: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Ins. Co. Phone: _____

Policy ID#: _____ Group #: _____

Name of Insured/Policyholder: _____ Date of Birth: _____

Relationship to Patient _____ Subscriber's SS#: _____

Is this insurance through an employer? ❑ Yes ❑ No If yes, please complete the following:

Employer's Name _____ Address: _____

City, State, Zip: _____

(OVER)

Patient's Full Name Date of Birth

Please read and sign below.

I hereby authorize the physicians and staff of Retina Specialists to perform procedures necessary to assess and diagnose my condition properly during any and all visits.

I authorize the release of any information concerning my care for purpose of claims to such agencies, third party payers, doctors and hospitals.

I hereby agree to pay the established charges for services incurred as a patient of Retina Specialists. I authorize payment directly to the doctors of Retina Specialists, and otherwise payable to me, but not to exceed the regular charges for the period of admission.

I understand that I am financially responsible for ALL charges arising from services rendered to me by the doctors regardless of insurance coverage.

I will cooperate in seeking, collecting and paying to the doctors any and all insurance proceeds. If the insurance proceeds cannot be paid directly to the doctors, I agree to collect payment and pay the doctors within five (5) business days of receipt.

I authorize the following person(s) to discuss my medical care and billing/insurance information with Retina Specialists Staff on my behalf.

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Signature of Patient: _____ Date _____

OR

Signature of Other
Responsible Person: _____ Date: _____

Relationship to Patient: _____

Race, Ethnicity & Language Form

Acct #

Retina Specialists
Robert Torti, M.D.
Santosh C. Patel, M.D.
Henry Choi, M.D.

Retina Specialists is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic backgorund. We will only use this information to review the treatment patients receive and make sure everyone gets the highest *quality of care.*

Race

Which category best describes your race?
(Of the following choices, please choose the one that best describes your race.)

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ Multiracial
- ☐ White
- ☐ Decline
- ☐ Asian (includes Pakistan or Indian origins)

Race Definitions: **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **Multiracial:** A person having more than one or a combination of the above origins

Ethnicity

First, do you consider yourself Hispanic/Latino?
(Of the following choices, please choose the one that best describes your ethnicity.)

☐ Yes ☐ No ☐ Decline

Language

What language do you feel most comfortable speaking with your doctor or nurse?
(Of the following choices please choose the one that best fits you.)

- ☐ English
- ☐ Tagalog
- ☐ Sign Language or other Auxiliary Aid or Service
- ☐ Spanish
- ☐ Hindi
- ☐ Unknown
- ☐ Vietnamese
- ☐ Italian
- ☐ Other _____
- ☐ Chinese
- ☐ Korean
- ☐ Decline

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Retina Specialists

2625 Bolton Boone Dr. • DeSoto, TX 75115 • 972.283.1516
1706 Preston Park Blvd. • Plano, TX 75093 • 972.599.9098
1600 Republic Pkwy, Suite 210 • Mesquite, TX 75150 • 214.393.5880
1011 N. Hwy. 77, Suite 103 A • Waxahachie, TX 75165 • 469.383.3368
www.retinaspecialists.net

Robert E. Torti, M.D.
Santosh C. Patel, M.D.
Henry Choi, M.D.
Hemang K. Pandya, M.D.

Diabetic Retinopathy
Macular Degeneration
Retinal Detachment
Ocular Tumors

Soon, within the next couple of months, we will be going to a paperless system. You will be able to complete and update all forms electronically and you will also be able to pay your bill online. To do this we will need your email address and we will not sell or share your email address.

We will also be confirming appointments by phone, text or email. Please enter your email address below and state your preference below for appointment reminders.

My email address is_____

I would like to receive my appointment reminder by (please circle your preference)

Email address listed above

Text, my cell phone number is _____

Phone, please call _____

Retina Specialists

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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Retina Specialists – (hereinafter referred to as "the Practice")**, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How — and why — information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within* ***the Practice.*** We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Retina Specialists

2625 Bolton Boone Dr.
DeSoto, TX 75115
972-283-1516

1706 Preston Park Blvd.
Plano, TX 75093
972-599-9098

1600 Republic Pkwy. #210
Mesquite, TX 75150
214-393-5880

1011 N. Hwy 77, Suite 103 A
Waxahachie, TX 75165
469-383-3368

Retina Specialists

Patient Consent and Acknowledgement of Receipt of Privacy Notices

I understand that as part of the provision of healthcare services, Retina Specialists creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____	_____
Patient's Printed Name	Date
_____	_____
Patient's Signature, or Guardian, if a Minor	Social Security Number *(for identification purposes only)*
_____	_____
Witness (Optional)	Date