# West Texas Retina Consultants

## *PATIENT INORMATION FORM*

Please print and provide complete information for each item.

First Name: ________________________ MI: ____ Last Name: ______________________ Today's Date: _______________

Mailing address: ______________________________ City: ____________________ State: ___________ Zip: _____________

Telephone: ________________________ Date of Birth: ___________ Age: ______ Sex: ____ Marital Status: __________

Social Security No.: _____________________________________ County: ______________________________________________

If you have been seen here before, under what name? ________________________________________________________________

**EMPLOYER INFORMATION:**

Employer's Name: ________________________________ Address: ____________________ City: _____________ State: ________

Zip: _____________________ Telephone: ________________________ Occupation: __________________________________

**RESPONSIBLE PARTY / PARENT / SPOUSE:**

Name: ____________________________ Relationship: _____________________ Occupation: __________________________

Employer: ______________________________ Social Security Number: _________________ Date of Birth: _____________

**EMERGENCY CONTACT: OTHER THAN SPOUSE:**

Name: ___________________ Relationship: ____________ Contact's Address:____________________ Telephone: ____________

**REFERRED BY: __________________________________ FAMILY PHYSICIAN: ____________________________**

**MEDICARE INFORMATION:**

Medicare Number: ________________________________ Medicaid Number: ___________________________________

**INSURANCE INFORMATION:**

Insurance Company: ___________________ Name of Policyholder: _____________________ Date of Birth: ______________

Address: ______________________________________________________ Telephone: ________________________________

Group Number: __________________________________ Policy Number: ___________________________________________

Policyholder's Employer and Address: ____________ ______________________________________________________________

**SUPPLEMENTAL INSURANCE INFORATION:**

Insurance Company: _________________________________ Name of Policyholder: __________________________________

Address: ______________________________________________________ Telephone: ___________________________________

Group Number: _______________________________________ Policy Number: _______________________________________

**Please read and sign below.**

I hereby authorize the physicians and staff of the West Texas Retina Consultants to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to WTRC, I understand that I am financially responsible for ALL charges arising from services rendered to me by WTRC.

Signature: X__________________________________________________________________ Date: _______________________

G B A C S L P D O New / Update WTRC Doctor: _________________________________ (over)

# West Texas Retina Consultants

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_______________________________________ _____________________________

**Patient's Full Name** **Date**

**Release Of Information**

I hereby authorize West Texas Retina Consultants to release any information concerning my care for purpose of claims to Federal, State, City or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

I permit a copy of this authorization to be used in place of the original.

**Signature of Patient:** _________________________ **Date:** ______________________

**Or**

**Signature of Other:** _________________________ **Date:** ______________________

**Responsible Person**

**Assignment of benefits**

I hereby agree to pay the established charges for services and all other charges incurred as a patient of West Texas Retina Consultants.

I further hereby authorize payment directly to WTRC, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to WTRC for changes not covered by this authorization.

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

I permit a copy of this authorization to be used in place of the original.

**Signature of Patient**: ___________________________ **Date**: ____________________

**Or**

**Signature of Other:** ___________________________ **Date:** ____________________

Name: Date:

**Medical and Family History:** Please mark (X) the following if they apply to yourself (S) or to your family members (F).

| S | F | | S | F | | S | F | |
|---|---|---|---|---|---|---|---|---|
| | | Anemia | | | Emphysema | | | Kidney Disease |
| | | Arthritis | | | Gout | | | Seizures |
| | | Asthma | | | Heart Attack | | | Stroke |
| | | Cancer | | | Hepatitis | | | Thyroid Disease |
| | | Diabetes (___#yrs) | | | High Blood Pressure | | | Vascular Disease |

**Other Medical Problems** (such as): Sexually Transmitted Disease HIV

Hepatitis Tuberculosis

Other ___________________________

**Previous Surgery** (non-eye surgery): Please give approximate dates no prior surgery

**Previous Eye Surgery** Please give approximate dates no prior eye surgery

**Other Illnesses or Injuries** Please give approximate dates

**Treatments or Hospitalizations:** Please give approximate dates

**Medications** (non-eye medications, include non prescription drugs): no medications

**Eye Medications** no medications

**Allergies and Drug Reactions** no allergies

**Social History:** Circle answer

Do you drink alcohol? no yes (if yes, explain) ______________________________

Do you smoke? no yes (if yes, explain) ______________________________

Any use of "street drugs?" no yes (if yes, explain) ______________________________

Do you live alone? no yes

Do you drive? no yes

Name: Date:

**REVIEW OF SYSTEMS:** If you currently have any problems in the following areas, please circle and explain.
**Please specify and explain.**

SKIN: itching, rash, infection, ulcer, tumors (growths), other none

LYMPH NODES: swelling, tenderness, other none

BONES, JOINTS, MUSCLES: muscles pain/cramps, joint pain/swelling, other none

ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other none

ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity, other none

HEAD: headaches, dizziness, vertigo, other none

EARS: hearing loss, ringing, infections, other none

NOSE: bleeding, loss of smell, congestion, sinus problems, other none

THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other none

NECK: pain, swelling, stiffness, other none

BREAST: tenderness, swelling lumps, discharge, other none

BLOOD: fever/chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other none

RESPIRATORY: wheezing, cough (productive/blood), difficulty breathing, asthma, other none

CARDIOVASCULAR: (heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other none

GASTROINTESTINAL: (stomach/intestine): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other none

GENITOURINARY: (genital/kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other none

NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other none

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other none

This form completed by: Patient Family Staff

History reviewed by ______________________________ M.D. Date __________

# NOTICE OF PRIVACY PRACTICES
West Texas Retina Consultants, P.A.

**Effective Date**: February 15, 2003

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. You have the right to obtain a paper copy of this notice upon request.

**Patient Health Information**

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

**How We Protect Your Patient Health Information**

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation for the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

**Example of Treatment, Payment, and Health Care Operations**

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example: nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment and to pharmacists who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

**Special Uses**

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Other Uses and Disclosures**

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events.

Research: We may use or disclose information for approved medical research

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Death: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

**Individual Rights**

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially; for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

**Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information to provide the Notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

**Changes in Privacy Practices**

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new notice in the waiting area and each exam room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

**Contact Person:**

**West Texas Retina Consultants, P.A.**
Patty Smith, Office Administrator
5441 Health Center Drive
Abilene, TX 79606
325-673-9806

# HIPAA PRIVACY NOTIFICATION

I, ____________________________________________________________
Have read and understand the HIPAA Privacy Notification for West Texas Retina Consultants, P.A.

A copy has been made available to me upon my request.

Signed: ________________________________________________________

Date: __________________________________________________________

If not signed, reason why acknowledgment not obtained: ______________________

_______________________________________________________________

_______________________________________________________________

Staff witness seeking acknowledgment:

Signed: ______________________________________________________

Date: ________________________________________________________