Retina Specialists

Raymond N. Sjaarda, M.D.
John T. Thompson, M.D.
David E. Barañano, M.D., Ph.D.

www.retinaspec.com

Dear New Patient:

We would like to take this opportunity to welcome you to Retina Specialists, and thank you for choosing our group. We are confident that our expertise in the latest technological advancements will provide you with the best possible options for your retinal health care.

Enclosed, please find a **New Patient Questionnaire** for you to complete in order to make your first visit with us as comfortable and comprehensive as possible. Please complete this form before you arrive for your first scheduled appointment. Please plan for at least a 2 – 3 hour appointment as a new patient; this will provide adequate time should special testing be required.

We will ask to view all of your current insurance cards at each of your appointments. Please remember to bring them to every appointment.

We have also enclosed a Financial Policy. Please read it carefully, sign it, and bring it with you to our office on the day of your appointment along with the questionnaire. Some sections may not apply to you depending on the type of insurance coverage you have.

If you have any questions regarding the Questionnaire or the Financial Policy, you may contact either our front desk at (410) 296-9700 or our billing department at (410) 296-9706. Our staff will be happy to discuss your concerns. You can also visit our website at www.retinaspec.com for additional information.

Thank you again for this opportunity to serve you.

Sincerely,

Retina Specialists

Patient Name: ________________________________ Acct No. ____________

LIST OF AUTHORIZED CONTACTS WITH WHOM RETINA SPECIALISTS CAN DISCUSS YOUR PERSONAL HEALTH INFORMATION AND/OR FINANCIAL INFORMATION

It is not necessary to list your physicians since we are allowed to communicate with them

Name / Address / Phone Number	Relationship	PHI type
Name: ____________ Address: ____________ ____________ Phone: ____________	Relationship: Spouse ☐ Child ☐ Other ☐ ____________	Health ☐ Financial ☐ Appts ☐
Name: ____________ Address: ____________ ____________ Phone: ____________	Relationship: Spouse ☐ Child ☐ Other ☐ ____________	Health ☐ Financial ☐ Appts ☐
Name: ____________ Address: ____________ ____________ Phone: ____________	Relationship: Spouse ☐ Child ☐ Other ☐ ____________	Health ☐ Financial ☐ Appts ☐
Name: ____________ Address: ____________ ____________ Phone: ____________	Relationship: Spouse ☐ Child ☐ Other ☐ ____________	Health ☐ Financial ☐ Appts ☐
Name: ____________ Address: ____________ ____________ Phone: ____________	Relationship: Spouse ☐ Child ☐ Other ☐ ____________	Health ☐ Financial ☐ Appts ☐

________________________________ ____________

Patient Signature **Date**

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Patient Registration Form

Last Name		First Name		Middle Initial
Street Address	Apt No.	City	State	ZIP
( )		( )		
Home Telephone Number		Other Telephone Number (work, cellular, etc)		
Date of Birth	Sex	Marital Status	Spouse's Name	
Email Address		Social Security Number		
Ethnicity		Race		
Employer		Patient Occupation		
Referring Physician Name		Address		

Do you have a Health Care Power of Attorney (POA)/Personal Representative? If yes, provide name and a copy of this document.

Please give your insurance cards to the front desk when you return this form

Insurance Information

Person responsible for charges not paid by insurance (if not patient)				Phone Number
Street Address	Apt No.	City	State	ZIP
Primary Insurance Company				
Policy Holder Name		Policy Holder DOB		Policy Number
Secondary Insurance Company				
Policy Holder Name		Policy Holder DOB		Policy Number
For HMO Subscribers - Primary Care Physician				Phone Number
Street Address	Apt No.	City	State	ZIP

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Financial Policy

Thank you for choosing Retina Specialists as your health care provider. We are committed to providing the best possible service and treatment so that your visit will be a success.

Please understand that payment of your bill enables us to maintain our standard of care. All patients must complete our Medical History Form and our Financial Policy Form before seeing your physician. Our office policy requires that we scan your insurance card(s) at every visit. You are responsible for providing us with your insurance information and keeping it up-to-date. If we experience a claim denial because your information is outdated or incorrect, any balance due becomes your responsibility.

If you would like to directly submit charges to your insurance company, we will provide you with the necessary documentation. Payment for services rendered to you will be due at the time of your visit. There is a $30.00 fee for charged for a check returned unpaid for any reason.

We accept cash, checks, Visa, MasterCard, Discover, or American Express.

Medicare

All of our physicians participate with Medicare and accept assignment. However, this does not mean that we accept Medicare payment as payment in full. Your co-pay is due and payable at the time of your visit. We will bill your secondary insurance company provided you supply us with that information. If Medicare is your only insurance, or your secondary insurance does not remit payment within 30 days, the balance will become your responsibility. If you have a third insurance provider, you will be responsible for paying any balance due to us and then filing a claim with that insurance company.

Commercial Insurance Companies (for patients without Medicare insurance)

As a courtesy to you, we will submit claims to no more than two commercial insurance companies provided we have the company's name and complete mailing address. If payment is not received from your insurance provider(s) within 30 days, as required by Maryland law, the balance will become your responsibility.

HMO/PPO Insurance

All of our physicians participate with various HMO/PPO insurance companies. If you need clarification as to whether we participate with your HMO/PPO, please call our office. It is your responsibility to obtain all referrals and authorizations for office visits prior to your appointment. If a valid referral or authorization is not available, you will need to sign a waiver making you responsible for the charges or we will reschedule your appointment. We accept cash, check, Visa, MasterCard, Discover, and American Express.

Patients without Insurance Coverage

If coverage by an insurance company is not active for the date of service, you will be required to pay 50% of the charges for that visit at the time the services are rendered. The remaining 50% will be billed to you and is payable within 30 days of receipt of the bill.

Medical Assistance of Maryland

All of our physicians participate with Maryland Medicaid. On the day of your visit, we will call to verify that your coverage is active. If coverage is active, we will bill Medicaid for you. If coverage is not active, the guidelines for patients without insurance will apply.

Medical Assistance for states other than Maryland

Because Medicaid coverage and reimbursement is controlled separately by each state, we will not be able to accept Medicaid from states other than Maryland. Please refer to the guidelines above for patients with no insurance coverage.

Payment of Balances Due

In the event that your insurance company sends payment for services directly to you, it is your responsibility to forward the payment along with a copy of the explanation of benefits to our office.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's arbitrary determination of what constitutes "usual and customary rates."

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Acceptance and Authorization to Bill Insurance

I have read, understand, and agree to this Financial Policy. By my signature below, I request that payment of authorized benefits be made on my behalf to Thompson & Sjaarda, P.A. dba Retina Specialists for services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company or any third-party payer any information needed to determine these benefits or the benefits payable for related services. I also understand and acknowledge that I am personally responsible to pay Retina Specialists in full for services that my health insurer will not cover due to non-payment of health insurance premiums**.**

Signature of Patient **Date**

Signature of Responsible Party (if patient is unable to sign) **Date**

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Patient Questionnaire

Name: Birth Date: Height: Weight:

Current or Previous Occupation:

Contact Person: Phone of Contact Person:

Family Doctor or Internist: Doctor's Phone:

Doctor's Address:

What is the main ocular reason for your visit today? Please describe the problem:

Severity: 1 2 3 4 5
(Mild) *(Moderate)* *(Severe)*

Timing: Sudden Gradual

Duration: ____ Hours ____ Days ____ Weeks ____ Months

Associated signs and symptoms: _____

Please Answer Every Question Yes or No - Thank You!

Have you ever had any of the following eye problems?

Yes	No		When
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Cataract	
☐	☐	Corneal disease	
☐	☐	Laser Treatment	
☐	☐	Diabetic Retinopathy	

Family History

Do any of your family members have:

Yes	No		Relationship to Patient
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Diabetes	

Patient's Name _____

Have you ever had any of the following other problems?

Yes	No		Please Elaborate (When, Type)
☐	☐	Diabetes	How long?
☐	☐	Problems with your Endocrine System (Pancreas, Thyroid)	
☐	☐	High Blood Pressure	How long?
☐	☐	Heart Problems (Heart Attack or Disease)	
☐	☐	Do you have a pacemaker or a defibrillator?	
☐	☐	Problems with your Blood or Excessive Bleeding	
☐	☐	Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema)	
☐	☐	Kidney Disease	
☐	☐	Stroke	
☐	☐	Cancer - What Kind	
☐	☐	Liver Disease (Hepatitis, Jaundice)	
☐	☐	Lupus	
☐	☐	Urinary Problems	
☐	☐	Neurologic Problems (Numbness, Seizures, Paralysis)	
☐	☐	Muscle or Joint Problems (Arthritis, etc.)	
☐	☐	Problems with your Immune System	
☐	☐	AIDS / HIV	

Smoker Status: Current smoker ☐ Former smoker ☐ Never smoker ☐

Surgeries

Eye (**including cataract surgeries**)	Other surgeries
1.	1.
2.	2.
3.	3.
4.	4.

Patient's Name _____

Medications and Supplements

Please list all medications and supplements you take, including eye drops.

If you have a list, check here ___ and we will copy it.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes**: If yes, list drug and type of reaction:

_____

_____

Review of Systems-Eye

Do you now have, or have you ever had, any of the following problems?

Yes	**No**		**Yes**	**No**	
☐	☐	Loss, Distorted, or Fluctuating Vision	☐	☐	Eye Pain/Soreness
☐	☐	Loss of Side Vision	☐	☐	Blurred Vision
☐	☐	Flashes of Light	☐	☐	Eye Injury
☐	☐	Floaters	☐	☐	Double Vision

Review of Systems-General

Do you now have, or have you ever had, any of the following problems?

Yes	**No**		**Please elaborate (when, type)**
☐	☐	Hay Fever/Sinus Problems	
☐	☐	Recent Fever or Weight Loss	
☐	☐	Digestive Problems, or Changes in Bowel Habits	
☐	☐	Skin Problems (Rashes, Excessive Dryness)	

Advanced Directives

Yes	**No**	
☐	☐	Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury?

_____

Person completing form | Relationship (if not the patient) | Date

Retina Specialists

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 access this medical information. Please review this notice carefully.

Retina Specialists creates a record of the care and services you receive at all of our facilities. We need this record to provide you with quality care and to comply with legal requirements. It is the policy of Retina Specialists to protect the confidentiality, integrity and security of the health and personal medical information of our patients and to prevent unauthorized access to, or unauthorized use or disclosure of such medical information. This policy applies to current and former patients of Retina Specialists.

We are required by law to maintain the privacy of your individually identifiable health information and personal medical information and to provide you with notice of our legal duties and privacy practices with respect to your medical information. Individually identifiable health and personal medical information are any medical information, including genetic information, obtained by Retina Specialists in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present and future medical information, that Retina Specialists receives from you as our patient.

Retina Specialists collects personal medical information in order to learn about your medical history and medical conditions, to render treatment and to collect payment for our services. We gather this medical information from your patient forms, health questionnaires, insurance cards and other forms that you will be asked to complete from time to time. In addition, we will assemble medical information based on our examinations as well as through discussions and conversations with you, your personal representatives and or your family members. Your healthcare plan or insurance carrier may also provide medical information to our office.

Your medical information is maintained in our offices within our computerized practice management system. We also maintain medical information about you in your medical chart. Retina Specialists limits access to your protected medical information to those employees and business associates who need to know that medical information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

I. How We May Use or Disclose Your Medical Information

The law permits us to disclose your medical information for the following purposes:

1. Treatment. We may use medical information about you to provide you with caring and quality medical treatment and services. We may share your medical information with a facility such as a hospital, laboratory, pharmacy, diagnostic service or another healthcare provider in order to efficiently coordinate your treatment plan. For example, we may routinely inform your primary care physician about your plan of care and we may disclose your medical information to laboratories, pharmacies and diagnostic facilities so that they may perform procedures and provide supplies requested by our physicians.

2. Payment. Your medical information may be used for claims management and to obtain payment from you, your insurance carrier or a third party. We will exchange data with you, your insurance carrier, or a responsible third party to determine if you are eligible for benefits and to secure payment for services we render. We may also tell your insurance carrier about a treatment or procedure that you are going to receive in order to obtain prior approval or to determine whether your plan will cover a specific treatment or procedure.

3. Health Care Operations. We may use and disclose your medical information for health care operations. These uses and disclosures are necessary to run the organization and in an effort to continually improve the quality and effectiveness of the care we provide. We may use your information, or combine it with other patients' information, to review our treatments and services, and to evaluate our physicians and staff. Operations include services provided by business associates (BAs), i.e., transcription and information systems maintenance. BAs may be given medical information in order to do their job. Other third parties may inadvertently come in contact with your information in assisting us with operations, i.e., maintenance or testing of medical equipment. We require these outside entities and BAs to appropriately safeguard your information.

4. Appointment Reminders. We may use and disclose medical information in order to contact you to remind you that you have an appointment or need follow-up at one of our facilities. We may leave reminder messages for you at your home, either on your answering machine or with a family member. We may also mail postcards, or send email, to you confirming that you have an appointment or need follow-up.

5. Treatment Alternatives and Health Related Products. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives, health related products or services offered by Retina Specialists, or send you educational materials.

6. Communication with Friends and Family. We may disclose your relevant medical information to a close personal friend, a family member who is involved in your care, to someone who helps pay for your care, or to any person you identify. We may use or disclose your relevant medical information to notify your friends or family members of your location, your general condition, or in the event of your death. If you do not want us to use or disclose your medical information for these purposes, you may object by notifying us orally or in writing of your objection. If you are unavailable or unable to object due to incapacity or emergency, our providers and staff will use their professional judgment and common practice to determine relevant medical information to disclose in your best interest.

7. Required by Law, Judicial or Administrative Proceeding or to Law Enforcement. We may disclose your medical information as required by law, or in the course of administrative or judicial proceedings. We may disclose your medical information to a law enforcement official for the following reasons:

a. In response to a court order, subpoena, search warrant or summons.
b. To identify or locate a suspect, fugitive, material witness, or missing person.
c. About a death we believe to be the result of criminal conduct.
d. About criminal conduct at our facilities.

8. To Avert a Serious Threat to Health or Safety and for Public Health Purposes. We may disclose your medical information to appropriate agencies such as DMV or the Food and Drug Administration (FDA) to prevent serious threat to your health and safety, or the health and safety of the public or another person. As required by law, we may disclose your medical information to public health authorities for purposes related to:

a. Preventing or controlling disease, injury or disability.
b. Reporting child, elder, or dependent adult abuse or neglect.
c. Reporting domestic violence.
d. Reporting problems with products and reactions to medications.
e. Reporting disease and infection exposure.
f. Reporting deaths.
g. Preventing an imminent threat to yourself or another person(s).

9. Deceased Person Medical Information. In the event of your death, we may disclose your medical information to coroners, medical examiners and funeral directors as necessary to carry out their duties.

10. National Security, Military Personnel, and Inmates. We may disclose your medical information to federal officials for military, intelligence, counterintelligence, or other national security purposes. If you are a member of the armed forces, we may disclose your medical information to military command authorities. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may

release medical information about you to the correctional institution or the law enforcement official.

11. Workers Compensation. We may disclose your medical information for workers' compensation or similar programs that provide benefits for work related injuries or illness.

12. Health Oversight Activities. We may disclose your medical information for activities authorized by law. These oversight activities include audits, investigations, inspections and physician licensure to name a few. The activities are necessary for the government to monitor the health care system, government programs, and compliance with laws.

II. Other Uses of Medical Information

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, this will stop any further use or disclosure of your medical information for the purposes that you originally authorized, except if we have already acted in reliance on your authorization.

1.Marketing and Fundraising. Retina Specialists will not sell your personal health information nor participate in marketing or fundraising endeavors for remuneration.

2. Research. We may use or disclose your protected health information for research purposes in limited circumstances.

III. Your Medical Information Rights

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

1. Right to Inspect and Copy. You have the right to inspect and request a paper or electronic copy of medical information that may be used to make decisions about your care by submitting a request in writing to our Medical Records department. You have the right to request a copy of your personal health information be sent to a designated person, and this request must be in writing, signed and clearly identify the designated person and where to send your medical information. If you request a copy of your medical information, we may charge you for the cost of paper copying, CD/USB device or similar portable device, mailing, or other costs associated with your request. Retina Specialists will provide a copy of your medical records to you within thirty days of your request (with one thirty day extension). If your personal health information is off-site,

Retina Specialists will provide a copy of your medical information to you within sixty days. An extension to this sixty day timeframe may be needed.

2. Right to Amend. You have the right to amend your medical information if you feel we have incorrect or incomplete medical information by submitting a request to us in writing to our Medical Records department. You must provide a reason that supports your request. We may deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by or for Retina Specialists; or if we determine that the record is complete and accurate. If we deny your request, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record that you believe to be incorrect or incomplete. The addendum will be attached to your medical record.

3. Right to an Accounting of Disclosures. You have the right to make a written request to us for a list of those instances where we have disclosed medical information about you (an "accounting of disclosures") other than for treatment, payment, health care operations, or where you specifically authorized a disclosure. You may submit your written request to our Medical Records department. Your request must state a time period desired for the accounting which may not be longer than six years and may not include disclosures dated before April 14, 2003. The first request in a twelve-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any charge.

4. Right to Request Restrictions. You may request that we not use or disclose medical information about you for treatment, payment, health care operations, or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. You must submit your request in writing to our Privacy Officer department. Your request must include: what medical information you want to limit; whether you want to limit use, disclosure or both; and to whom you want the limits to apply. We will consider your request but our processes may not be able to accommodate it and we are not legally obligated to agree to your request. We will inform you of our decision on your request.

If you pay out of pocket, in full, for health care services you receive, and upon receiving your written request, Retina Specialists agrees to restrict disclosure to your health plan. This also applies for full, out of pocket payment for follow-up care you receive.

5. Alternate Contact Information for Confidentiality Purposes. You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home. To request alternative methods of contacting you confidentially, you must make a request in writing at the time of service or in writing to our Privacy Officer. We will attempt to accommodate reasonable requests.

6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may obtain a paper copy of this notice at the front desk of any of our offices. You may also obtain a copy of this notice at our website: www.retinaspec.com.

IV. Changes to this Notice of Privacy Practices

Retina Specialists reserves the right to change this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all medical information we maintain, including medical information that was created or received prior to the date of the change. We will provide you with revised notices by posting the current notice in our facilities or by providing copies of the current notice showing the effective date. Retina Specialists is required by law to abide by the notice currently in effect.

V. Breach Notification

If an unauthorized disclosure of your personal health information occurs, Retina Specialists will conduct a risk assessment to determine if there is a high probability that your personal health information has been compromised. If at the conclusion of the risk assessment it is discovered there is a high probability your personal health information has been compromised, a breach notification will be carried out according to the guidelines set forth in the HIPAA/HITECH guidelines.

VI. Contacts for Complaints

For further information about this notice or to make a complaint if you believe your privacy rights have been violated, contact our Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. Our Privacy Officer can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Our Contact Information:

Medical Records
Retina Specialists
6569 N. Charles Street, Suite 605
Baltimore, MD 21204
410-296-9700
866-738-4627 (866-RETINAS) – toll-free

Maryanth Constantine, Privacy Officer
Retina Specialists
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