Retinal Diagnostic Center

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□ 200 Jose Figueres Ave, Ste. 240 San Jose, CA 95116 Ph. (408) 937-0928 Fax (408) 254-8954
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Lingmin He, M.D., M.S. **Reema Syed, M.D.** **Louis Cai, M.D.**

Patient Information

PATIENT NAME:

_____ _____ _____
LAST FIRST MIDDLE

ADDRESS: _____ **APT/STE #**_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

HOME PHONE: _____ **WORK/CELL PHONE:** _____

EMAIL: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

RELATIONSHIP TO RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____ **PH#:** _____

REFERRED PHYSICIAN: _____

ADDRESS: _____ **PH#:** _____

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Emergency Contact

NAME: _____

RELATIONSHIP: _____ **PH#:** _____

NAME: _____

RELATIONSHIP: _____ **PH#:** _____

Responsible (or Insured) Party Information

RESPONSIBLE PARTY NAME:

_____ _____ _____
LAST FIRST MIDDLE

ADDRESS: _____ **APT/STE #**_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

HOME PHONE: _____ **WORK/CELL PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

Accident Information

DATE OF ACCIDENT _____

WORK RELATED _____ **AUTO** _____ **OTHER** _____

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PATIENT MEDICAL HISTORY INFORMATION FORM

Patient Name _____ **Date** _____

Please check appropriate box if you have history of:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Abnormal Bleeding
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Kidney Problem
- ☐ Allergies
- ☐ Prematurity at Birth
- ☐ Other Eye Problems _____

_____

- ☐ Emphysema
- ☐ Migraine Headaches
- ☐ Asthma
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High Myopia
- ☐ Lazy Eye, Strabismus/ Amblyopia
- ☐ Eye Surgery
- ☐ Smoking

Family Eye Problems:

- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Retinitis Pigmentosa
- ☐ High Myopia
- ☐ Other _____

Are you allergic to any medication? ☐ Yes ☐ No
If yes, what medications _____

Please list all current medications _____

_____

_____

Pharmacy Name and Address

_____

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State of California Patient Questionnaire

The California Health and Safety Code (Section 128737) requires that we collect the following information for the Office of Statewide Health Planning and Development. In compliance with this code, we ask that you please complete the following questionnaires.

Patient Name _____ **Date** _____

Gender ☐ Male ☐ Female

Language _____

Marital Status _____

(Please circle one)

Ethnicity

African American	American Indian/Alaskan Native	Asian
Asian Indian	British	Cambodian Pacific
Caucasian	Central American	Filipino
French	Hispanic or Latino	Korean
Islander	Non Hispanic or Non Latino	Decline to State

Other _____

Race

African American	American Indian/Alaskan Native	Caucasian
Hispanic Latino	Hawaiian	Other Pacific Islander
Unknown	Decline to State	

Other _____

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FINANCIAL POLICY

Thank you for selecting Retinal Diagnostic Center (RDC) for your eye care needs. The following information outlines financial responsibilities related to payment for your professional services.

You, the patient, are ultimately responsible for all charges associated with your care. Retinal Diagnostic Center participates with a variety of insurance plans. We refer to “in network” as the insurance companies that we have a contract agreement with. Please be aware, you incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check your insurance company for coverage and participation details. It’s also your responsibility to let us know if there is a change with your insurance coverage.

We will submit insurance claims on your behalf to your primary insurance and one secondary insurance carrier. However, your insurance is a contract between you and your insurer, and it is your responsibility to know and understand the requirements of your insurance plan. We are not responsible if you do not follow the specific terms of your insurance agreement and if we do not receive payment from them, you will be responsible.

For each visit, it is your responsibility to:
• Bring your insurance cards for medical coverage, and picture ID.
• Be prepared to pay for your co-pay and non-covered services.
• Obtain any referrals that your insurance requires.
• Provide a valid physical address that you will be able to receive statements or correspondence from RDC.

If there is a remaining balance due after your insurance carrier pays, you will be billed. If that balance is not paid within 60 days, we send outstanding balances to an outside collection agency without further notice. Payment arrangements can be made, but it is your responsibility to contact the Billing Office before it is turned over to an outside agency.

We accept cash, check, VISA, MasterCard, Discover and American Express.

If the patient is a minor (17 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, required referrals, insurance, and picture ID cards.

If you have any questions or need assistance, please do not hesitate to contact our Billing Office 408-547-9513, Monday-Friday, 8:00 am to 5:00 pm.

Your signature below indicates that you have read and agree to this Financial Policy.

_____ _____

Patient or Guardian’s Signature Date

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations [§164.508(a)]

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations [§164.506(a)]

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative

Printed Name

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Retinal Diagnostic Center (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”
By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Representative

_____
Printed Name

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____
Signature of Patient or Legal Representative

_____
Printed Name

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.