STARER RIZZO RUFFINI OPHTHALMIC ASSOCIATES, P.C.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Starer Rizzo Ruffini Ophthalmic Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- **Protected Health Information (PHI) may be disclosed or used for treatment, payment or health care operations.**
- **Starer Rizzo Ruffini Ophthalmic Associates has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice**
- **Starer Rizzo Ruffini Ophthalmic Associates reserves the right to change the Notice of Privacy Policies**
- **The patient has the right to restrict the uses of their information but Starer Rizzo Ruffini Ophthalmic Associates does not have to agree to those restrictions**
- **The patient may revoke this Consent in writing at any time and all future disclosures with then cease**
- **Starer Rizzo Ruffini Ophthalmic Associates may condition treatment upon the execution of this Consent.**

I authorize release of my individual health information to the following:

_____(relationship)_____

This consent was signed by:_____/_____
(Printed Name – Patient or Representative) (Signature)

Relationship to Patient (if other than patient):_____Date:_____

In front of _____
(Printed Name – SRRO Representative)

PATIENT HISTORY RECORD

_____

Patient Name Date

_____

Family Doctor Name, Address and Telephone Number

_____

Emergency Contact Name Relationship Telephone Number

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR MEDICAL HISTORY:

1. Do you have any drug or food allergies?
   Yes___ No___ If YES, please list_____

   _____

2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or “lazy eye”, retinal detachment)?
   Yes___ No___ If YES, please explain_____

   _____

3. Do you take any eye medications?
   Yes___ No___ If YES, please list_____

   _____

4. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   Yes___ No___ If YES, please explain_____

   _____

5. Do you take any medications?
   Yes___ No___ If Yes, please list_____

   _____

   _____

6. Have you ever had any surgery?
   Yes___ No___ If YES, please give date and reason_____

   _____

7. Have you ever been hospitalized?
   Yes___ No___ If YES, please give date and reason_____

   _____

(PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE OF FORM)

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

	YES	NO	If YES, please explain
Chronic fever, unexpected weight gain/loss, fatigue	___	___	_____
Ear/nose/throat problems (e.g.) hearing loss, sinus problems, sore throat)	___	___	_____
Heart problems (e.g. chest pain, irregular hear beat)	___	___	_____
Respiratory problems (e.g. shortness of breath,coughing)	___	___	_____
Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting, abdominal pain)	___	___	_____
Urinary problems (e.g. pain, discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excess dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	___	___	_____
Neurologic problems (e.g. weakness, headaches)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes___ No___ If YES, please explain:_____

_____

Do you smoke? Yes___ No___. If yes, how much?_____

Do you drink alcohol? Yes___ No___. If yes, how much?_____

Patient Signature_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

LAST NAME: _____

FIRST NAME: _____

CHECK ONE: ☐MR. ☐MRS. ☐MS. ☐MISS ☐M.D.

MARITAL STATUS: S M D W
(CHECK ONE)

ADDRESS: _____

STATE:_____ ZIP:_____

TELEPHONE HOME: ( ) _____

WORK: ( ) _____

E-MAIL ADDRESS: _____

DATE OF BIRTH:_____
MONTH DAY YEAR

SOCIAL SECURITY NO.: _____

SEX: ☐ MALE ☐ FEMALE RACE:_____

EMPLOYER: _____

ADDRESS: _____

OCCUPATION OF PATIENT:_____

SPOUSE'S NAME_____

Are you covered under your spouse's insurance? ( ) YES ( ) NO

PARENT/GUARDIAN _____
(IF MINOR)

ADDRESS (IF DIFFERENT):_____

WHO REFERRED YOU TO OUR PRACTICE?

NAME: _____

ADDRESS: _____

*UPDATE:*_____
Sign and Date

TODAY'S DATE: _____
MONTH DAY YEAR

INSURANCE INFORMATION

DO YOU HAVE? (CHECK APPROPRIATE BOXES)

1. PRIMARY _____

ID#_____

GROUP# _____

SUBSCRIBER _____DOB_____

RELATIONSHIP TO APPLICANT/SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

2. SECONDARY_____

ID#_____

GROUP# _____

SUBSCRIBER _____DOB_____

RELATIONSHIP TO APPLICANT/SUBSCRIBER

☐ SELF ☐ SPOUSE ☐ DEPENDENT

ADDRESS OF APPLICANT/SUBSCRIBER

_____

_____

IF PATIENT IS A MINOR, WHO MAY AUTHORIZE TREATMENT OF PATIENT?

_____

_____

HIPPA PRIVACY ACT

WHO MAY WE RELEASE MEDICAL INFORMATION TO?

_____

_____

_____

MEDICAL INFORMATION WILL ONLY BE RELEASED TO THOSE PERSONS LISTED ABOVE, IN ADDITION TO THE HIPAA GUTDELINES FOR THE RELEASE OF HEALTH INFORMATION.

*UPDATE:*_____
Sign and Date

AUTHORIZATIONS FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

MEDICARE
I request that payment of authorized Medicare benefits be made on my behalf to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

DATE:_____ SIGNED: _____

MEDIGAP
I request that payment of authorized Medigap benefits be made on my behalf to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to Medigap insurer any information needed to determine these benefits payable for related services.

DATE:_____ SIGNED: _____

OTHER INSURANCE
I, the undersigned, authorize payment of medical benefits to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. for any services furnished to me by the physicians. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

DATE:_____ SIGNED: _____

WORKMEN'S COMPENSATION
The services and treatment you receive from our physicians may have resulted from an injury or illness which is job related and is covered by Worker's Compensation. If this is true, it is your responsibility to report your injury and/or illness directly to your employer. You must also inform us at the time of each visit that you are a Worker's Compensation case, and furnish us the name and address of your employer or the insurance carrier who covered your company.

I hereby authorize my insurance benefits to be paid directly to Starer-Rizzo-Ruffini Ophthalmic Associates, P.C. and I am financially responsible for "non-covered services." I also authorize the physician to release any information required to process this claim.

DATE:_____ SIGNED: _____

PATIENT RESPONSIBILITY
I understand that I am financially responsible for any amounts that are due from me. If my account is uncollectible through normal means, a collection agency referral will be made and I will be responsible for all collection fees in addition to the outstanding balance on my account.

DATE:_____ SIGNED: _____