SOUTHEASTERN RETINA ASSOCIATES

PLEASE COMPLETE ALL THE ENCLOSED INFORMATION BEFORE ARRIVING FOR YOUR APPOINTMENT. YOU WILL BE DILATED AT EVERY VISIT THEREFORE IT IS ALWAYS RECOMMENDED THAT YOU BRING A DRIVER.

Dear Patient:

We would like to welcome you to Southeastern Retina Associates. Please visit our website www.southeasternretina.com for more information about our practice, physicians, and various locations in Tennessee, and the surrounding states.

Thorough retinal evaluation requires that you spend more time in our office than would be necessary for a general eye examination. During the initial visit, we will ask you questions about your eyes, your general health, and any medications that you take. Collection of medical information and a variety of tests must be performed both before and after dilation of the pupils. Please bring a companion to drive you home after the dilated eye exam.

Please remember that traffic and parking can add to delays at some of the different locations and to allow for additional travel time. If you discover that you are going to be late please call us as soon as possible. We do understand unforeseeable delays may occur. We will try to accommodate the occasional patient who is late, but this may not always be possible without compromising the quality of your care and depriving other patients of their own scheduled appointment times.

Thank you,
Southeastern Retina Associates

Appointment Date: _____

Appointment Time: _____

Appointment Location:_____

NOTICE OF PRIVACY POLICIES
For
Southeastern Retina Associates, P.C. (SERA)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Introduction

At SERA we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This Notice is effective October 1, 2002 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit SERA a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal documents describing the care you received,
- Means by which you or a third party payer can verify that services billed where actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for medical research,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how you health information is used helps you to ensure accuracy, better understanding who, what, when, where, and why others may access your health information, and make more informed decision when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of SERA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Southeastern Retina Associates, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation or the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Sandra H. Brock at 865-588-0811.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in treating you once you're released back to your primary eye care physician.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations

For example: Members of our organization may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Other forms of Disclosure

Business Associates:
There are some services provided in our organization that utilize outside agencies. These include laboratories, and other forms of business associates that provide us a service. To protect your health information we require each of our business associates to sign a contract with our organization stating they will safeguard your information.

Notification:
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition

Communication with Family:
We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when an institutional review board has approved their research, that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

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

Federal and State Agencies:
As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Patient Demographics

SOUTHEASTERN RETINA ASSOCIATES, P.C.

Diseases and Surgery of the Retina and Vitreous

Patient's Name: _____ **Responsible Party:** _____

Address: _____ **Zip:** _____ **City:** _____ **State:** _____

Sex: □ Male □ Female **Title** □ Mr. □ Mrs. □ Miss □ Other _____

Phone: □ Home _____-_____-_____ □ Work _____-_____-_____ □ Cell _____-_____-_____

Please check the box for the phone number above that you would like us to use as your primary contact.

E-mail: _____ **Marital Status:** □ Single □ Married □ Divorced □ Widow □ Unknown

Date Of Birth: ____/____/_____ **Social Security #** _____-_____-_____ **Employer:** _____

Emergency Contact Information

Name: _____ **Relationship:** _____ **Contact Number:** _____

What Physician referred you to us?

NAME & ADDRESS: _____

Who is your Primary Care Physician?

NAME & ADDRESS: _____

Name of the Doctor you are seeing today: _____ **Employer:** _____

Responsible Party Information if patient is a Minor

Name: _____ **Address:** _____ **Phone:** _____-_____-_____

Relationship: _____ **Date of Birth:** _____/_____/_____ **SSN:** _____-_____-_____

Employer: _____ **Work Phone:** _____ **Cell:** _____

Spouse's Name: _____ **Spouse's SSN#:** _____

Spouse's Employer: _____ **Spouse's Work Phone:** _____

Spouse's Date of Birth: _____/_____/_____ **Spouse's Cell Phone:** _____

Is your visit related to an accident? □ Yes □ No **Will this be covered under Worker's Compensation?** □ Yes □ No

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I authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care operations (TPO). I accept full financial responsibility for services rendered by Southeastern Retina Associates, PC., and agree to pay all reasonable collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Southeastern Retina Associates, PC should they elect to receive such payment. My signature below indicates that I have read and fully understand the forth written authorization. **Signature:** _____ **Date:** _____

MEDIGAP (SIGNATURE ON FILE STATEMENT FOR MEDICARE TO CROSSOVER TO 2ND INSURANCE)

Name of Beneficiary _____ **HICN** _____ **Medigap Policy Number** _____

I request that the payment of authorized Medigap benefits be made either to me or on my behalf to Southeastern Retina Associates, PC for any services furnished me by the provider. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services. **Beneficiary Signature:** _____ **Date:** _____

My signature below indicates that a copy of The Privacy Policy for Southeastern Retina Associates, PC has been made available to me.

Signature: _____ **Date:** _____

MEDICAL AND OCULAR

SOUTHEASTERN RETINA ASSOCIATES, P.C.

Diseases and Surgery of the Retina and Vitreous

SERA MD _____

Account # _____

Patient Name: _____ **Sex:** _____ **Age:**_____ **Date:** _____

Eye Doctor:_____ **Address:** _____

Medical Doctor: _____ **Address:** _____

Please answer the following questions to the best of your ability.

Give dates, a brief description, and which eye was involved to any **yes** question.

Present Illness Please describe your current eye problem: _____

_____

Ocular History **Have you ever had any of the following:**

Cataracts □ Right Eye □ Left Eye □ No **Cataract Surgery** □ Right □ Left Surgeon and Date: _____

Macular Degeneration □ Yes □ No **Glaucoma** □ Yes □ No **Retinal Detachment** □ Yes □ No

Eye Injury □ Yes □ No If yes, please explain _____

Other Eye Problems: _____

Medical History — Have you ever had any of the following…..

Seasonal Allergies	□ Yes □ No	**Food Allergies** □ Yes □ No Please List: _____
High Blood Pressure	□ Yes □ No	Controlled with medication □ Yes □ No
Heart Problems	□ Yes □ No	□ Heart Attack □ Angina □ Rhythm Problems □ Congestive Failure □ Other _____
Neurology	□ Yes □ No	□ Stroke □ Seizures □ Migraine □ Tremors □ Parkinson's □ Neuropathy □ Bells Palsy □ Mini Stroke (TIA)
Endocrine	□ Yes □ No	□ Diabetes _____ How Long? _____ Last Blood Sugar □ Thyroid □ Sarcoidosis _____ Last A1C Hemoglobin
Pulmonary	□ Yes □ No	□ Asthma □ Emphysema □ Lung Disease □ COPD □ Phlebitis □ Tuberculosis □ Shortness of Breath □ Pneumonia □ Bronchitis
Genitourinary	□ Yes □ No	□ Prostate □ Kidney Disease □ Kidney Stones □ UTI
Gastroenterology	□ Yes □ No	□ GERD –reflux □ IBS □ Ulcers □ Hiatal Hernia □ Acid Reflux □ Diverticulitis □ Crohn's Disease
Hematology	□ Yes □ No	□ Anemia □ Lupus □ Hepatitis □ High Cholesterol □ HIV □ Sickle Cell Disease □ Lyme Disease □ Cancer □ Skin □ Breast □ Prostate □ Lung □ Other _____
Rheumatology	□ Yes □ No	□ Arthritis □ Sjogren's Syndrome
Psychiatry	□ Yes □ No	□ Depression □ Anxiety □ Other _____
Surgical History		□ Gallbladder - Cholecystectomy □ Appendectomy □ Hysterectomy □ Bypass - CABG □ Heart Stent □ Hernia - Herrniorhaphy □ Tonsilectomy □ Prostatectomy □ Other _____

Medications - Please provide list if additional space is needed.

Medication	Strength	Frequency

Eye Medications

Medication	Strength	Frequency

Allergies To Medications

☐ No Known Drug Allergies

□ Yes Please List Medication Allergies and Symptoms: _____

Family History

Is there an eye disease/problem which runs in your family? Please list the family relationship for any eye disease/problem you select.

□ Macular Degeneration □ Retinal Detachment □ Glaucoma □ Cataracts Relationship: _____

Is there any significant medical disease which runs in your family? Please list the family relationship for any medical disease you select.

□ High Blood Pressure □ Heart Disease □ Lung Disease □ Kidney Disease □ Cancer □ Diabetes

Relationship: _____

Social History

Marital Status □ Single □ Married □ Divorced □ Seperated □ Widow □ Unknown

Do you Smoke □ Every Day □ Someday □ Former Smoker □ Never Smoked

Do you drink Alcohol □ None □ Occasional/Social □ 1 to 2 Drinks per day □ 3 to 4 Drinks per day

Do you have a history of substance abuse □ No □ Yes If Yes please explain: _____

Occupation □ Retired □ Home Maker □ Other _____

Review of Symptoms

Please check the box below if you have any of the following symptoms…..

Cardiovascular □ Chest Pain □ Shortness of Breath □ Swelling of Feet □ Shortness of Breath when Laying Flat

Constitutional □ Fever □ Weight Loss □ Fatigue □ Loss of Appetite □ No Fevers, Fatigue, or Weight Loss

Endocrine □ Excess Thirst □ Excessive Urination □ Heat Intolerance □ Cold Intolerance

Gastrointestinal □ Diarrhea □ Abdominal Pain □ Nausea

Genitourinary □ Pain/Burning on Urination □ Blood in Urine

Hematology □ Easy Bruising □ Prolonged Bleeding □ Blood Transfusion in the Past

HENT □ Runny Nose □ Hearing Loss □ Sore Throat

Integumentary □ Rash □ Change in Mole

Musculoskeletal □ Muscle Aches □ Joint Pain □ Difficulty Laying Flat due to Musculoskeletal Discomfort

Neurologic □ Tremor □ Dizziness □ Paralysis of Extremities □ Weakness □ Headaches □ Scalp Tenderness

Respiratory □ Wheezing □ Cough □ Coughing Blood □ No Cough or Wheezing

Reviewed By:

Physician's Signature:

_____

Date: _____