

# SOUTHEASTERN RETINA ASSOCIATES

**PLEASE COMPLETE ALL THE ENCLOSED INFORMATION BEFORE ARRIVING FOR YOUR APPOINTMENT.**

**NOTE THAT YOU MAY 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](http://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, so consider allowing 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 patients who are late, but please understand 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: \_\_\_\_\_



We are pleased to announce the upcoming implementation of new technology, which will include a new and improved patient payment portal, ability to pay by phone any time, and an electronic registration and check-in process. Here are some of the benefits you will receive from these new tools:

- \* More options to easily pay and research your balance
  - Call us any time and use our new touchtone phone payment option
  - Online using our new payment portal
    - Access previous statements and payment information
    - Scan the QR code on your statement to instantly access your account
    - Complete payments in just a few clicks with no usernames or passwords to remember
    - Choose or update your delivery preference (email, text, or mail)
    - Minimize paper waste
  - Touchless payments in the office or wherever you are using your cell phone/tablet
- \* Simplified registration
  - Receive a text or email days in advance of your appointment with a link to the electronic documents, allowing plenty of time to gather information or obtain assistance from a family member or caregiver
  - Complete the documents and scan identification cards in the comfort of your home or wherever you may be—when it is convenient for you
  - Provide updated information ensuring any necessary authorizations are obtained prior to your appointment
  - Touchless check-in using your phone or tablet

**Please provide your information below to get started!**

- Phone number for voice reminders (home or mobile): \_\_\_\_\_
- Email: \_\_\_\_\_
- Text Message – Mobile/cell number: \_\_\_\_\_

I hereby consent to receiving emails and auto-dialed and/or artificial or pre-recorded collection or health-care related message calls and text messages to my email, cellular phone number and any other telephone numbers, as applicable, provided during any interaction, agreement or communication with the RevSpring Licensor, its clients and contractors, and/or their affiliates, agents and contractors, including any of their billing or account management companies and/or debt collectors. I understand that I can opt out at any time.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Printed Name if signed on behalf of patient

\_\_\_\_\_  
Relationship (parent, guardian, personal representative)



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## **FINANCIAL POLICY, updated June, 2019**

Thank you for choosing Southeastern Retina Associates (SERA) as your retina healthcare provider. We are committed to providing excellent care for our patients. Our Financial Policy (FP) is outlined below. A detailed explanation of your responsibility is provided. Please read the FP in its entirety. Your signature below will acknowledge your receipt and understanding of SERA's FP.

- **We ask that you bring your insurance card(s) with you to each visit.** It is your responsibility to keep SERA updated with your active insurance coverage so that prior authorizations and referrals can be obtained, and payment can be sought from the appropriate insurance carrier. Failure to provide current, active insurance information will result in unpaid claims becoming your complete financial responsibility.
- **Any copay, coinsurance or deductible required by your insurance company must be paid at the time services are rendered.** SERA will accept cash, check, money order, Care Credit, Visa, Mastercard, Discover or American Express. *Ultimately your bill is your financial responsibility.*
- **It is common for our patients to require injection therapy for the conditions we treat. These treatments are expensive, and can result in significant out-of-pocket expenses, particularly if you do not maintain careful attention to your available benefits and follow through with the necessary paperwork and protocols.** While we will do everything we can to make the process simple, it is important to reiterate that *you are ultimately responsible for the cost of the care you receive.*
- **SERA will file your primary, secondary and tertiary insurance plans.** We are participating providers for Medicare, most Medicare Advantage plans, most Medicaid plans, Tricare, BlueCross BlueShield and most other commercial insurance plans. Our Corporate Billing Office will be happy to answer any questions you may have regarding our provider participation in your plan. As a contracted provider, we will accept your carrier's allowed charge amount for the services being provided. You are responsible for the difference between the allowed amount and what your insurance pays.
- **Medicare patients in temporary care of a Skilled Nursing Facility ("SNF") have restrictions on services provided by our physicians as the SNF is responsible for your care while admitted to their facility.** It is critical that you inform our staff if you currently reside in a SNF as well as provide that facility's information. Special arrangements must be made with that SNF **prior** to services being provided. Failure to provide this information to SERA could result in you being responsible for any unapproved service.



**SOUTHEASTERN  
RETINA  
ASSOCIATES**

*Diseases and Surgery of the Retina and Vitreous*

James H. Miller, Jr., M.D.  
Joseph M. Gunn, M.D.  
Tod A. McMillan, M.D.  
Howard L. Cummings, M.D.  
Stephen L. Perkins, M.D.  
D. Allan Couch, M.D.  
Richard I. Breazeale, M.D.  
Nicholas G. Anderson, M.D.

Cris Larzo, M.D.  
R. Keith Shuler, Jr., M.D.  
Francis Char Decroos, M.D.  
Rohan J. Shah, M.D.  
Devon Ghodasra, M.D.  
Ailee M. Laham, M.D.  
Mark E. Kleinman, M.D.  
Scott M. Barb, M.D.

Asgar A. Haider, M.D.  
Michael A. Magee, M.D.  
Jonathan S. Fuerst, M.D.  
Sophie Cai, M.D.  
Claxton Baer, M.D.  
Jacob T. Cox, M.D.  
*Joseph M. Googe, Jr., M.D., Emeritus*  
*John C. Hoskins, M.D., Emeritus*

- **Uninsured (Self-Pay) patients are required to pay in full at the time of service** unless prior arrangements have been made with our corporate billing office. SERA offers a prompt pay discount if payment in full is made at the time of service, or within certain designated time frames. If you do not fulfill your responsibilities under any negotiated payment arrangement, any discounts applied will be removed. **Any discounted fee must be paid in full at the time of service.**
- **Outside collection agency assistance may be pursued if your balance remains unpaid for 60 days after the date of service.**
- **Financial Hardship Assistance** is available if you suffer from such hardship. Consideration will be given following the completion of SERA’s Financial Hardship Application with all requested documentation provided. Approval, including any discount offered and the length of such discount, will be determined on a case by case basis, and this policy is subject to change at any time at the sole discretion of SERA. Contact our Corporate Billing Office for additional information. **Any discounted fee must be paid in full at the time of service.**
- **You will incur a fee of \$25 for completion of various forms (disability, FMLA, etc.) as well as a request for copies of your medical records.** This fee is due prior to receipt of the complete form and/or copying of records.
- **An additional fee of \$30 may be incurred for any returned check from your banking institution.**

**Our Corporate Billing Office can be reached at 423-756-1512.**

**By signing below, I acknowledge receipt and understanding of the Southeastern Retina Associates Financial Policy.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Chattanooga/N Georgia**  
1605 Williams Road, #201  
Hixson, TN 37343  
**Phone: (423) 756-1002**  
Fax: (423) 756-1004

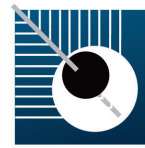
**Greater Knoxville Area**  
1124 E Weisgarber Rd, #207  
Knoxville, TN 37909  
**Phone: (865) 588-0811**  
Fax: (865) 934-3892

[www.southeasternretina.com](http://www.southeasternretina.com)

**Tri-Cities/Virginia**  
2412 N John B. Dennis Hwy  
Kingsport, TN 37660  
**Phone: (423) 578-4364**  
Fax: (423) 578-4372

**Corporate/Billing offices** 9050  
Executive Park Drive, #202A  
Knoxville, TN 37923  
**Phone: (865) 584-4108**  
Fax: (865) 934-3892

# Patient Demographics



SOUTHEASTERN  
RETINA  
ASSOCIATES

Which doctor are you seeing today? \_\_\_\_\_

**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:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient's Employer:** \_\_\_\_\_ **Primary Insurance Name:** \_\_\_\_\_

*If you have insurance through someone else:*

**Subscriber Name:** \_\_\_\_\_ **Subscriber Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Subscriber's Employer:** \_\_\_\_\_

**What Physician referred you to us? NAME & ADDRESS:** \_\_\_\_\_

**Primary Care Physician? NAME & ADDRESS:** \_\_\_\_\_

**Responsible Party 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

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 pro-vider. 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:** \_\_\_\_\_

I understand that Southeastern Retina Associates, P.C.'s Notice of Privacy Practices is available to me at [www.southeasternretina.com](http://www.southeasternretina.com), and further understand I can request a paper copy today. I understand this document advises me of how certain health information about me may be used and disclosed by the practice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Identifying Information and Privacy Options

**Southeastern Retina Associates (SERA) is now required to collect the following information from all of our patients.** Please check the appropriate boxes below:

<p><b>Preferred Language:</b></p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Ethnicity:</b></p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Not Hispanic/Latino</p> <p><input type="checkbox"/> Unknown</p>	<p><b>Race:</b></p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Native Hawaiian/other Pacific Islander</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other</p>
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### Privacy Options:

In some cases, it is not possible to reach our patients during work hours to **discuss test results, future appointments and account balances.** Your response to the questions below will give us guidance when we cannot contact you personally.

**YES**  **NO** SERA may leave messages on my answering machine/voice mail, or speak with the person answering my home phone, regarding appointments.

### I would prefer to receive appointment reminders via: (select one or more)

- Text Message (enter cell #): \_\_\_\_\_
- Email: \_\_\_\_\_
- Phone/voice mail: \_\_\_\_\_

**YES**  **NO** SERA may speak with other people (listed below) regarding my insurance, billing questions, or financial arrangements.

\_\_\_\_\_

**YES**  **NO** SERA may speak with other people (listed below) regarding my medical care, lab or test results, or other medical information.

\_\_\_\_\_

### Account and Billing Information:

#### I would prefer to receive account / billing information via: (select one or more)

- Text Message (enter cell #): \_\_\_\_\_
- Email: \_\_\_\_\_
- Paper

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# MEDICAL AND OCULAR HISTORY



**Southeastern Retina Associates, P.C.**

Diseases and Surgery of the Retina and Vitreous

SERA MD: \_\_\_\_\_

Account # \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
General Eye Doctor (Not Retina): \_\_\_\_\_ City or Address: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ City or Address: \_\_\_\_\_

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

**Present Illness — Please describe your current eye problem:** \_\_\_\_\_

## Ocular History — Have you ever had any of the following?

**Cataracts**  Yes  No *If yes, which eye?*  Right  Left **Cataract Surgery**  Right  Left *Surgeon/Date:* \_\_\_\_\_  
**Macular Degeneration**  Yes  No *If yes, which eye?*  Right  Left  
**Glaucoma**  Yes  No *If yes, which eye?*  Right  Left **Retinal Detachment**  Yes  No *If yes, which eye?*  Right  Left  
**Eye Injury**  Yes  No *If yes, please explain and list which eye:* \_\_\_\_\_  
**Any history of lazy eye, patching, or muscle surgery as a child?**  Yes  No *If yes, which eye?*  Right  Left  
**Please list any other eye problems:** \_\_\_\_\_

## Medical History — Have you ever had any of the following?

<b>Heart Problems</b>	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Rhythm Problems <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Neurology</b>	<input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Tremors <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mini Stroke (TIA) <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Endocrine</b>	<input type="checkbox"/> Diabetes: Type 1 ____ Type 2 ____ How long? _____ Last Blood Sugar: ____ Last A1c: ____ <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> N/A <input type="checkbox"/> Other: ____
<b>Pulmonary</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung Disease <input type="checkbox"/> COPD <input type="checkbox"/> Phlebitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Genitourinary</b>	<input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> UTI <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Gastroenterology</b>	<input type="checkbox"/> GERD <input type="checkbox"/> Acid Reflux <input type="checkbox"/> IBS <input type="checkbox"/> Ulcer <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Hematology</b>	<input type="checkbox"/> Anemia <input type="checkbox"/> Lupus <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Cancer: Skin ____ Breast ____ Prostate ____ Lung ____ Other <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Rheumatology</b>	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
<b>Psychiatry</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____

## Surgical History — Have you ever had any of the following surgeries?

Gallbladder (Cholecystectomy)  Bypass (CABG)  Heart Stent  Appendectomy  Tonsillectomy  Prostatectomy  
 Hysterectomy  Hernia (Herniorrhaphy)  Blood Transfusion  Other: \_\_\_\_\_

**Medications—Please provide list if additional space is needed.**

Medication	Strength	Frequency

**Eye Medications**

Medication	Strength	Frequency	Eye

**Allergies**

Are you allergic to any medications?  Yes  No *If yes, please list medications and side effects:* \_\_\_\_\_

Are you allergic to Latex?  Yes  No **Do you have seasonal allergies?**  Yes  No

Do you have any food allergies?  Yes  No *If yes, please list the foods you are allergic to:* \_\_\_\_\_

**Family History**

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

**Macular Degeneration** / Relationship: \_\_\_\_\_  **Retinal Detachment** / Relationship: \_\_\_\_\_

**Glaucoma** / Relationship: \_\_\_\_\_  **Cataracts** / Relationship: \_\_\_\_\_

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

**High Blood Pressure** / Relationship: \_\_\_\_\_  **Heart Disease** / Relationship: \_\_\_\_\_

**Diabetes** / Relationship: \_\_\_\_\_  **Kidney Disease** / Relationship: \_\_\_\_\_

**Cancer** / Relationship: \_\_\_\_\_  **Lung Disease** / Relationship: \_\_\_\_\_

**Social History**

**Marital Status**  Single  Married  Divorced  Separated  Widowed

**Do you smoke?**  Every Day  Some Days  Former Smoker  Never Smoker

**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?**  Yes  No *If yes, please explain:* \_\_\_\_\_

**Occupation**  Retired  Homemaker  Student  Disabled  Unemployed  Other: \_\_\_\_\_

**Review of Symptoms — Are you experiencing any of the following symptoms?**

**Cardiovascular**  Chest Pain  Shortness of Breath  Swelling of Feet  Shortness of Breath when Lying 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**  Blood in Urine  Pain or Burning During Urination

**Hematology**  Easy Bruising  Prolonged Bleeding

**HENT**  Runny Nose  Hearing Loss  Sore Throat

**Integumentary**  Rash  Change in Mole

**Musculoskeletal**  Muscle Aches  Joint Pain  Difficulty Lying Flat Due to Musculoskeletal Discomfort

**Neurologic**  Tremor  Dizziness  Headache  Weakness  Scalp Tenderness  Paralysis of Extremities

**Respiratory**  Wheezing  Cough  Coughing Blood  No Cough or Wheezing

Reviewed By: \_\_\_\_\_ Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_





*Diseases and Surgery of the Retina and Vitreous*

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**INFORMATION REGARDING DILATING EYE DROPS**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow your doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Depending on your condition, your doctor may dilate one or both eyes. However, your doctor will typically dilate both eyes and you should therefore anticipate that both of your eyes will be dilated at every visit.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my physician with Southeastern Retina Associates and/or such Southeastern Retina Associates' assistants as may be designated by him/her to administer dilating eye drops.

\_\_\_\_\_  
Patient (or person authorized to sign for patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# Pharmacy Information

**Patient Name:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy**

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Pharmacy Phone:** \_\_\_\_\_