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) 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:_____

SOUTHEASTERN RETINA ASSOCIATES

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)

SOUTHEASTERN RETINA ASSOCIATES

Diseases and Surgery of the Retina and Vitreous

Joseph M. Googe, Jr., M.D.
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.
Asghar A. Haider, M.D.
John C. Hoskins, M.D., Emeritus

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.

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- **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

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

Which doctor are you seeing today? _____

SOUTHEASTERN RETINA ASSOCIATES

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, 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:** _____

SOUTHEASTERN RETINA ASSOCIATES

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:

Preferred Language:	**Ethnicity:**	**Race:**
❑ English ❑ Other: _____	❑ Hispanic ❑ Not Hispanic/ Latino ❑ Unknown	❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/other Pacific Islander ❑ White ❑ Other

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?

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

SOUTHEASTERN RETINA ASSOCIATES

Diseases and Surgery of the Retina and Vitreous

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:_____