IDAHO RETINA CENTER PLLC

MRN (*Office use*) : _____

Legal Name: _____ Date of Birth : _____

Preferred Name: _____Cell Phone: _____ Home Phone:_____

Select primary number: ☐ Cell Phone ☐ Home Phone

Address:_____

City: _____State: _____ Zip: _____

Email: _____

Gender: ☐ Male ☐ Female ☐ Other: _____ Social Security Number: _____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Race:
☐ Native American/Alaskan
☐ Caucasian/White
☐ Asian
☐ African American/Black
☐ Hispanic/Latino
☐ Native Hawaiian/ Pacific Islander

Language Preference:
☐ English
☐ Spanish
☐ Other: _____

Emergency Contact Name: _____ Relationship: _____

Primary Number: _____ Secondary Number: _____

Family Doctor: _____
Office/location: _____
Phone Number: _____

Referring Doctor: _____
Office/location: _____
Phone Number: _____

Responsible Party: (If minor, guardian, or Power of Attorney)

Name: _____ Phone: _____

Address: _____ Relationship: _____

****Please complete this section if the patient is NOT the policyholder****

Primary Insurance Information:
Insurance Name:_____
Name of policy holder:_____
Relationship to patient:_____
DOB:_____
ID#:_____

Secondary Insurance Information:
Insurance Name:_____
Name of policy holder:_____
Relationship to patient:_____
DOB:_____
ID#:_____

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Name: _____ Date of Birth: _____

Mark all symptoms you are *currently* experiencing below:

- ☐ Loss of Vision
- ☐ New Floaters
- ☐ Flashes of Light
- ☐ Eye Pain/Soreness
- ☐ Distortion
- ☐ Blurred Vision
- ☐ Other:_____
- _____
- _____

In which eye are you experiencing these symptoms? ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Mark all medical diagnosis that have apply to you *(past and present)*

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis - Osteo / Rheumatoid
- ☐ Arrhythmia (irregular heart beat)
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer-
  Type:_____
  _____
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes -Type I
- ☐ Diabetes - Type II
- ☐ Emphysema
- ☐ GERD/Gastric Reflux
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack - Year: _____
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lupus
- ☐ Migraines -Ocular
- ☐ Migraines -Classic
- ☐ Prostate Complications
- ☐ Thyroid Disease
- ☐ Seizure Disorder
- ☐ Stroke

Additional Medical Conditions:_____

Have you ever had any GENERAL SURGERIES?

- ☐ Tonsillectomy *Year:* _____
- ☐ Gallbladder *Year:* _____
- ☐ Appendectomy *Year:* _____
- ☐ Hernia Repair *Year:* _____
- ☐ Amputation *Year:* _____
- ☐ Hip Replacement *Year:* _____
- ☐ Knee Replacement *Year:* _____
- ☐ Shoulder Surgery *Year:* _____
- ☐ Pacemaker *Year:* _____
- ☐ Heart Stent *Year:* _____

Please list additional surgeries & dates below:

_____

_____

Have you ever had any OCULAR SURGERIES?

- ☐ Cataract Surgery *Year:* _____
- ☐ Corneal Surgery *Year:* _____
- ☐ Eyelid Surgery *Year:* _____
- ☐ Eye Muscle Surgery *Year:* _____
- ☐ Glaucoma Surgery *Year:* _____
- ☐ Laser Surgery *Year:* _____
- ☐ LASIK *Year:* _____
- ☐ Retinal Surgery *Year:* _____

Please list additional surgeries & dates below:

_____

_____

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Medications

List all current medications you are taking *(Please Include all over-the-counter, herbals, vitamins, mineral supplements, dietary supplements).*

Name:	**Dose:**	**Frequency:**

**** If medications exceed space provided, please attach a list.****

Preferred Pharmacy**:** _____ Location**:**_____

Do you have any ALLERGIES TO MEDICATIONS? ⬜Yes ⬜No

If yes*, please list them below:*

Medication:	**Reaction:**

Family History: Label family members*, Example: Mother, Brother, Child, Uncle, Grandmother*

⬜Blindness	*Who:*_____	⬜Cancer	*Who:*_____
⬜Diabetes	*Who:*_____	⬜Retinal Detachment	*Who:*_____
⬜Stroke	*Who:*_____	⬜Retinal Tear	*Who:*_____
⬜Macular degeneration	*Who:*_____	⬜Glaucoma	*Who:*_____
⬜High Blood pressure	*Who:*_____	⬜Heart Attack	*Who:*_____

Current Smoker ⬜ How many packs per day?: _____

Former Smoker ⬜ When did you quit?:_____

Never Smoked ⬜ Any current or former issues with substance abuse? ⬜Yes ⬜No

Do you currently drink any alcohol? ⬜1-2 Daily ⬜3-4 Daily ⬜Occasionally ⬜Never

Have you had any *falls* in the past year?

⬜ No ⬜ Yes, How many falls?: ____ Did you sustain any injury from prior falls? ⬜Yes ⬜No

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Authorization for Release of Identifying Health Information for Family/Friends

This is an authorization to release Protected Health Information to **family and friends** named below.

Name:	Relationship:	We may discuss the following:
		☐ Appointment information Date, time, location ☐ Test Results ☐ Exam Findings ☐ Billing/Balances ☐ All of The Above ☐ Other ______________
		☐ Appointment information Date, time, location ☐ Test Results ☐ Exam Findings ☐ Billing/Balances ☐ All of The Above ☐ Other ______________
		☐ Appointment information Date, time, location ☐ Test Results ☐ Exam Findings ☐ Billing/Balances ☐ All of The Above ☐ Other ______________
		☐ Appointment information Date, time, location ☐ Test Results ☐ Exam Findings ☐ Billing/Balances ☐ All of The Above ☐ Other ______________

I affirm that I have read and understand this form. By my signature, I authorize the disclosure of my health information as described on this form.

Patient Name: ____ Date:__________________

Patient Signature (or legal Guardian): ____

IDAHO RETINA CENTER PLLC

Name: _____ Date of Birth: _____

MEDICAL CONSENT

I consent and authorize the doctors of Idaho Retina Center, PLLC to (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by member of my doctor's staff as well as by the doctor him (her)self and this routine work-up often includes the instillation of eye drops for various reasons - such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students/nurses/nurse's aides, technicians and agents and employees of Idaho Retina Center, PLLC providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here DOES NOT extend to initiation of any oral or IV medication nor any surgical procedures, injections or lasers performed whether in the office or at a surgical facility. Separate consent must be obtained for any of these procedures.

RELEASE OF INFORMATION

I understand that, to the extent necessary to determine responsibility for payment and to obtain reimbursement, Idaho Retina Center, PLLC may disclose portions of the patient's record, including medical records and/or billing information, to any person or entity which is or may be responsible for all or any portion of Idaho Retina Center, PLLC charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release same and copies of any medical records to Idaho Retina Center, PLLC, the Health Care Financing Administration, its agents or carriers, and my insurance carrier (s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

HIPAA NOTICE. I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information.

DISPOSITION OF TISSUE, ETC. I authorize Idaho Retina Center, PLLC to retain, preserve, and use for scientific purposes or disposal at the convenience of Idaho Retina Center, PLLC any specimens or tissues taken during my treatment

IDAHO RETINA CENTER PLLC

PRIOR AUTHORIZATION

I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. *NOTICE*: *Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services at Idaho Retina Center, PLLC. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage and any restrictions on choosing a provider. Idaho Retina Center, PLLC offers a full range of the services you may need; however, in order to receive maximum insurance payment you need to know your health insurance benefits coverage and which providers and services the insurance will fully pay for*.

FINANCIAL AGREEMENT

I understand that, even though I may have insurance and authorize this office to submit charges on my behalf, I am financially responsible for all charges not paid by my insurance. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Idaho Retina Center, PLLC /Dr. Ali Torab Parhiz. I hereby authorize said assignee to release all information necessary to secure payment. I am aware that a co-payment may be required for each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed.

Idaho Retina Center, PLLC reserves the right to charge a Returned Check fee. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether the account is referred to a collection agency.

*There is a **$30 charge** for each form that needs to be filled by the practice or records / images to be printed. Example: FMLA, Disability, etc.*

MISSED APPOINTMENTS

I agree to pay the cost for all visits missed or canceled late unless I notify Idaho Retina Center, PLLC of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me. These fees will not be billed to my insurance. Appointments are the responsibility of the client and/or parents/guardian and reminders from the provider should not be expected. If you cancel or miss an appointment without proper notice, you will be charged a ***$75 no-show fee or $25 late-cancelation fee*** and will not be allowed to reschedule until that fee is paid. $100 will be charged for all late cancellations and no-shows for procedures.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

Patient Name**:** _____ Date:_____

Patient Signature (or legal Guardian): _____