RETINA & VITREOUS OF TEXAS

Joseph A. Khawly, MD FACS
Eric R. Holz, MD FACS
Hassan T. Rahman, MD FACS
Emmanuel Y. Chang, MD PhD FACS
Jonathan H. Tzu, MD FACS
Prethy Rao, MD MPH

PATIENT INFORMATION		
Patient's name (first and last):		Birth Date:
Birth Sex: ☐ M ☐ F ☐ Unknown	Gender Identity (optional):	
Social Security No.:		

CONTACT INFORMATION		
Cell Phone:	Home Phone:	Work Phone:
Email:		
Address:		
City:	State:	Zip:
Preferred contact method: (please select only one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email		
May we leave a detailed message: ☐ Yes ☐ No	☐ No emails ☐ No text messages	
Emergency Contact:	Relationship:	Phone:

PREFERRED PHARMACY		
Name:	Phone:	Zip:

REFERRING PHYSICIAN		
Name:	City:	Phone:

PRIMARY CARE PHYSICIAN		
Name:	City:	Phone:

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Please bring your insurance card(s) to your appointment and give it to the receptionist	
Ins. Co. Name:	Ins. Co. Name:
Policy Holder's Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Member ID Number:	Policy Member ID Number:
Policy Group Number:	Policy Group Number:

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MEDICAL HISTORY QUESTIONNAIRE

Patient's name (first and last):	Birth Date:

What symptoms or complaints do you have with your vision (please be specific, including dates if necessary)?

List all major illnesses, injuries, or surgeries (including on your eyes) that you have had in the past:

List any medications (including any eye medications) that you take:

May we request this information from the pharmacy for you? ☐ Yes ☐ No

If no, please list all medications you currently take:

List any allergies you have (including medication allergies):

Do you presently have any problems with the following areas?

Integument (skin)	☐ Yes	☐ No	☐ Yes	☐ No	Neurological
Ears, Nose, Mouth, Throat	☐ Yes	☐ No	☐ Yes	☐ No	Lymph Nodes
Respiratory (lungs)	☐ Yes	☐ No	☐ Yes	☐ No	Hematopoietic (blood)
Cardiovascular (heart)	☐ Yes	☐ No	☐ Yes	☐ No	Allergic / Immunologic
Gastrointestinal (stomach)	☐ Yes	☐ No	☐ Yes	☐ No	Genitourinary
Bones, Joints, Muscles	☐ Yes	☐ No	☐ Yes	☐ No	Do you drink Alcohol?
Are you taking blood thinners?	☐ Yes	☐ No	☐ Yes	☐ No	Do you smoke?
If yes, what are you taking? _____			☐ Yes	☐ No	Exposure to HIV?

_____ _____

Patient / Guardian Signature Date

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ASSIGNMENT OF BENEFITS

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Retina and Vitreous of Texas, PLLC. A copy of this authorization can be considered an original for insurance purposes.

MINOR PATIENTS

Minor patients must be accompanied by a parent, authorized adult family member, or legal guardian to all appointments. In addition, the financial responsibility for a minor patient is the responsibility of the accompanying adult unless prior arrangements have been made with this office.

EYE EXAM

I agree to and understand that my eye(s) must be dilated for the doctor to perform a thorough examination. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Retina and Vitreous of Texas, PLLC suggest that I evaluate my need for alternative transportation, and the decision is solely mine, and Retina and Vitreous of Texas, PLLC is in no way responsible for that decision.

FINANCIAL POLICY

A more detailed version of this financial policy is available **here**. A summary of your financial responsibility is below.

As a courtesy to you, our patient, Retina and Vitreous of Texas, PLLC will bill your insurance directly for services provided. Whatever amounts your insurance classifies as patient responsibility will be billed to you. For scheduled procedures and treatments, payment for services is due in full at the time of service. We will make every effort to create an accurate estimate of your financial responsibility prior to providing these services. If you have questions about your estimated financial responsibility, please call our billing department for assistance.

Payment in full for an account balance is due prior to your next visit. Our billing staff is available to assist with questions regarding your balance. If your account is past due, we will take all necessary steps to collect on the debt owed, including possible referral to a collection agency which may affect your credit record.

SELF PAY POLICY: We understand that you might not have insurance for your visit. We require a $250 deposit at the time of service. This will be applied toward the actual charges for your visit. If the charges for your visit exceed $250, the remaining balance will be billed to you. In the even the visit charges total less than $250, the difference will be refunded to you within 10 business days.

For your convenience, we accept cash, check, all major credit cards, and offer a secure online payment portal. Post-dated checks are not accepted. A $25.00 return check fee will be assessed if your check is returned by your bank.

_____ | _____

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NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE ISSUED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY**.
2. **How we may use and disclose your health information:** We may use health information about you without your authorization for treatment, to receive payment for your treatment, for healthcare operations, law enforcement efforts, and public health reporting. If you agree, we may use your information for fundraising and/or marketing initiatives.
3. **Your rights**: In most cases, you have the right to review or request a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information. In addition, you may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. Use and disclosure of protected information in violation of such restrictions will be a violation of the federal privacy standards.
4. **Our legal duty**: We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice. The notice will be available at all Retina and Vitreous of Texas, PLLC offices and on our website. You can also request a copy of our notice at any time. For mor information about our privacy policies, contact our Privacy Officer.
5. **Privacy complaints**: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our Privacy Officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our Privacy Officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Retina and Vitreous of Texas, PLLC, Privacy Officer, 6565 West Loop South., Suite 400, Bellaire, TX 77401. Phone number: (713) 799-9975.

ADDITIONAL PERSON(S) WE MAY DISCUSS YOUR HEALTH INFORMATION WITH		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

☐ I **DO NOT** allow Retina and Vitreous of Texas, PLLC to share any information pertaining to sexually transmitted diseases, behavioral health services, or mental health services that may be included in my medical record.

My signature below acknowledges I have received this Notice of Privacy Practices.

_____ | _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION		
Patient's name (first and last):		Birth Date:
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	
Email:		

I AUTHORIZE THE FOLLOWING PERSON OR ORGANIZATION TO DISCLOSE THE ABOVE PATIENT'S PROTECTED HEALTH INFORMATION FOR TREATMENT/CONTINUING MEDICAL CARE PURPOSES [*OFFICE USE ONLY - PLEASE DO NOT FILL OUT]:

*			
	Person / Organization Name:		
	Address:		
	City:	State:	Zip:
	Phone:	Fax:	

PLEASE SEND THE REQUESTED INFORMATION TO:

RETINA AND VITREOUS OF TEXAS, PLLC
ATTN: MEDICAL RECORDS
6565 WEST LOOP SOUTH, SUITE 400
BELLAIRE, TX 77401
PHONE: (713) 799 – 9975
FAX: (713) 799-1095

PLEASE EXCLUDE THE FOLLOWING INFORMATION FROM THE RELEASE:

☐ Drug, Alcohol, or Substance Abuse Records
☐ Mental Health Records
☐ HIV/AIDS Test Results/Treatments
☐ Genetic Information (including genetic test results)

IF YOU ARE UNSURE OF HOW TO COMPLETE THIS SECTION YOU MAY LEAVE IT BLANK. PLEASE SIGN BELOW SO IF THE NEED ARISES WE CAN REQUEST RECORDS ON YOUR BEHALF.

_____ | _____

Patient / Guardian Signature Date