Retina EyeCare

Arpenik Avakian, MD

We would like to welcome you to Retina EyeCare. As a new patient, we appreciate the opportunity to be of service to you and intend to make your visit with us helpful and informative.

Please plan to arrive for your appointment 15 minutes before your scheduled time with the new patient forms completed, and the following items:

- Insurance card(s)
- Drivers license or picture identification
- Co-pay and referral if required by your insurance
- List of any current medications and dosages
- List of any medications that cause an allergic reaction
- Copies of medical records you may have regarding your condition

You can expect your appointment to last about 90 minutes. Eye examination and diagnostic tests require dilating both pupils. You may consider having someone to drive you home as your eyes will be sensitive to light after the exam.

If you have limited mobility and require assistance, please bring a friend or family member with you to your appointment that is able to assist you.

Enclosed in this package, we also provide driving directions to our office.

We welcome your comments and suggestions on your experience. Please call (425) 275-9975 if you have further questions.

Thank you.

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PATIENT INFORMATION SHEET

Ms/Mrs./Miss/Mr.
PATIENTS NAME: _____ __
FIRST **M.I.** **LAST**

(Mail) Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Birth date: _____ _____ **( ) Male ( ) Female** **Social Security:** _____

Employer: _____ **Business Phone: ( )** _____

Patients Spouse or Partner's Name: _____

Employer: _____ **Phone #: ( )** _____

EMERGENCY CONTACT: (person we may contact in case of an emergency not living in your household):

_____
Name Relationship Phone Number

REFERRED BY: _____
LAST NAME FIRST NAME PHONE NUMBER

_____
STREET ADDRESS CITY, STATE FAX NUMBER

PRIMARY PHYSICIAN: _____
LAST NAME FIRST NAME PHONE NUMBER

_____
STREET ADDRESS CITY, STATE FAX NUMBER

Cardiologist: _____

Pharmacy Name/Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Subscriber Name: _____

Subscriber date of birth: _____ Relationship to patient: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber date of birth: _____ Relationship to patient: _____

PLEASE READ THE FOLLOWING CAREFULLY

Assignment, Release and Financial Agreement: I authorize treatment to the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I am financially responsible for account payment. A billing fee of up to $50 on past due accounts over 90 days will be charged. Balances over 30 days may incur an interest charge of 1% per month, 12% APR (RCW19.52). I have also been informed of the $40 fee (per RCW62A2-515 & 520) on checks returned to NSF. In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing costs and any other costs the court determines proper.

_____ _____
Patient Signature Date

Retina EyeCare, PLLC
Financial Policy

We are committed to providing you with the highest level of service and quality eye care. If you have medical insurance, we will strive to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. We encourage you to contact your insurance company prior to your appointment to clarify your coverage. Ultimately, any and all financial liability rests with the patient. In addition, your insurance company does not guarantee payment to us.

In order to clarify Retina EyeCare's Financial Policy, we have listed our financial requirements:

Patient Without Insurance Coverage
Payment in full at the time of initial service is required. We accept cash, check, CareCredit, Visa and MasterCard to assist you with your medical needs.

PPO, HMO, non-Contracted, and other private insurance Patients
We will bill your insurance for you. Co-pays must be paid at the time of service, as required by your insurance company contract. You may be left with a balance when co-pays, deductibles or non-covered services exist. This balance is due upon receipt after the billing statement has been sent.

Original Medicare Patients
We will bill Medicare, and if you have a supplemental insurance, we will also bill your Medicare supplement. You will receive a statement from our office after Medicare and/or your supplemental insurance has paid their portion of your charges or applied the charges to your deductible or co-insurance.

Medicaid, Molina Healthcare and Community Health Plan of Washington Patients
We accept these medical plans. You will be asked to provide us with your medical insurance card and your Medicaid Services Card for billing purposes.

United Healthcare Medicare, Humana, Soundpath Health and other Managed Medicare Plans
We accept these medical plans and most other Medicare Advantage or Managed Medicare Plans. Some plans require a referral authorization from your primary care physician to see a specialist. We ask that you obtained this from your primary care physician prior to your visit. We will bill your plan directly.

After-Hours Fee
If an emergency arises and you need to be seen after regular office hours, on holidays, on Saturday or Sunday, we will bill your insurance an additional fee. If your insurance does not pay this fee, we will bill you directly.

Auto Accidents and other accidents when liability insurance applies
Patients being seen in our office for evaluation regarding their accident claim will be asked to pay at the time of the visit. It will be your responsibility to obtain reimbursement from your liability insurance.

Collection Accounts
If your account becomes delinquent, we will send it to an outside Collection Agency. You will need to contact the Collection Agency directly to clear your account.

No Shows & Cancellation Policy
In the event that you need to cancel an appointment, we require at least 48 hours notice in advance of your appointment.

PATIENT MEDICAL STATUS AND HISTORY RECORDS

Name: _____ Date (MM/DD/YY): _____

PLEASE ANSWER THE FOLLOWING:

WHAT IS (ARE) THE PRESENT PRIMARY PROBLEM(S) WITH YOUR EYE(S)? _____

_____

_____

1. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

☐No ☐Yes If Yes, please explain: _____

_____

2. Have you ever had any eye surgery?

☐No ☐Yes If Yes, please provide the date and surgical procedure: _____

. _____

3. Have you ever had any surgery (other than eye surgery)?

☐No ☐Yes If Yes, please provide date and surgical procedure: _____

_____

4. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, heart problems, stroke, etc.)?

☐No ☐Yes If Yes, please explain: _____

_____

5. Have you ever been hospitalized?

☐No ☐Yes If Yes, please provide date and reason: _____

_____

6. Do you take any medications?

☐No ☐Yes If Yes, please indicate medication and dosage: _____

_____

_____

7. Do you have any drug or food allergies?

☐No ☐Yes If Yes, please explain: _____

FAMILY AND SOCIAL HISTORY

Do any medical or diseases run in your family? (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

☐No ☐Yes If Yes, please explain: _____

_____

Do you smoke? _____ If yes, how much?_____
Drink alcohol? _____If yes, how much? _____

Current occupation or previous profession? _____

OVER►

REVIEW OF SYSTEMS **Do you currently have any of the following problems?**	**No**	**Yes**	**If Yes, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue, weakness.	☐	☐	_____
Ear/nose/throat problems: hearing loss, sinus problems ringing in the ears.	☐	☐	_____
Cardiovascular (heart/blood vessels): chest pain, irregular heartbeat, blood clots, High blood pressure, heart murmur, stent, chronic heart failure, pacemaker. high cholesterol, circulation problems.	☐	☐	_____
Respiratory (lungs/breathing): shortness of breath, wheezing, coughing, asthma, sleep apnea, emphysema (c-pap machine?)	☐	☐	_____
Gastrointestinal (stomach/intestines): heartburn, diarrhea, vomiting nausea, GERD, ulcer, hiatal hernia, acid reflux, constipation.	☐	☐	_____
Genitourinary (genitals/kidney/bladder): pain or discomfort, blood in urine kidney disease and/or dialysis, frequent urination, prostrate problems.	☐	☐	_____
Skin: rashes, excessive dryness, rash, psoriasis, eczema, roseacia	☐	☐	_____
Musculoskeletal (bones/joints/muscles): muscle aches, swollen, painful joints osteoporosis, rheumatoid arthritis, lupus, gout, fibromyalgia.	☐	☐	_____
Neurological: e.g., numbness, weakness, headaches, paralysis, parkinsons, alzheimers, multiple sclerosis, peripheral neuropathy, stroke.	☐	☐	_____
Endocrine: e.g., thyroid problems, excessive sweating, diabetes	☐	☐	_____
Hematopoietic (blood): bruise easily, anemia, leukemia	☐	☐	_____
History of hepatitis, HIV/AIDS or other bloodborne pathogens	☐	☐	_____
Psychiatric: depression, anxiety, dementia, on meds	☐	☐	_____

M.D. Signature: _____Date:_____
Updated Information/ Date:

_____

_____

_____

_____

_____

Name: _____ **Date:** _____

CONSENT TO LEAVE A MESSAGE/SHARE INFORMATION WITH FAMILY

□ I consent to information regarding my or another family member's detailed appointment reminders/instructions be left on my voice mail or answering machine. I understand that sensitive information as noted below will be excluded.

Consent for shared information with family

□ I wish family members to have access to my health care information. The name(s) listed below are family members to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

	Name	Relationship
1.	_____	_____
2.	_____	_____

X Patient Signature: _____

Patient/Parent Signature

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It is my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

NOTICE OF PRIVACY PRACTICES:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Retina EyeCare.

X Patient Signature: _____

NOTICE OF FINANCIAL POLICY:

I acknowledge receipt of the FINANCIAL POLICY OF Retina Eyecare.