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.

Edmonds Medical Plaza • 21616 76th Ave W • Suite 104 • Edmonds, WA 98026
Tel. (425) 275-9975 • Fax (425) 275-9964 www.retinaeyec.com

THIS IS A FRAGRANCE FREE FACILITY

PLEASE RESPECT THE HEALTH OF OUR

STAFF AND CLIENTS BY REFRAINING FROM

THE USE OF SCENTED PRODUCTS

THANK YOU!

RETINA EYECARE, PLLC

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

PRIMARY PHYSICIAN: _____
LAST NAME FIRST NAME PHONE 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**

Updated 11/21/2018

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? List attached ☐

☐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): High blood pressure, chest pain, heart murmur, stent, irregular heartbeat, blood clots, high cholesterol, circulation problems, chronic heart failure, pacemaker	☐	☐	_____
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	☐	☐	_____

Have you received an annual Flu shot: Date: _____

Have you received a Pneumonia Vaccination: Date:_____

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.	_____	_____

XPatient 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.

XPatient Signature: _____

NOTICE OF FINANCIAL POLICY:

I acknowledge receipt of the FINANCIAL POLICY OF Retina Eyecare.

XPatient Signature: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

○ Patient refused to sign this acknowledgement even though the patient was asked to do so and then was given the NOTICE OF PRIVACY PRACTICES AND THE FINANCIAL POLICY.

Signature of provider representative: _____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.

RETINA EYECARE
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Retina EyeCare respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of Retina EyeCare. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Front Office Coordinator
425-275-9975

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our office to pick one up, Retina EyeCare 21616 76th Ave W Ste 104, Edmonds, WA 98026, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:
Office Manager
425-275-9975

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the clinic manager at Retina EyeCare. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. **Uses and disclosures that require your authorization.**

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

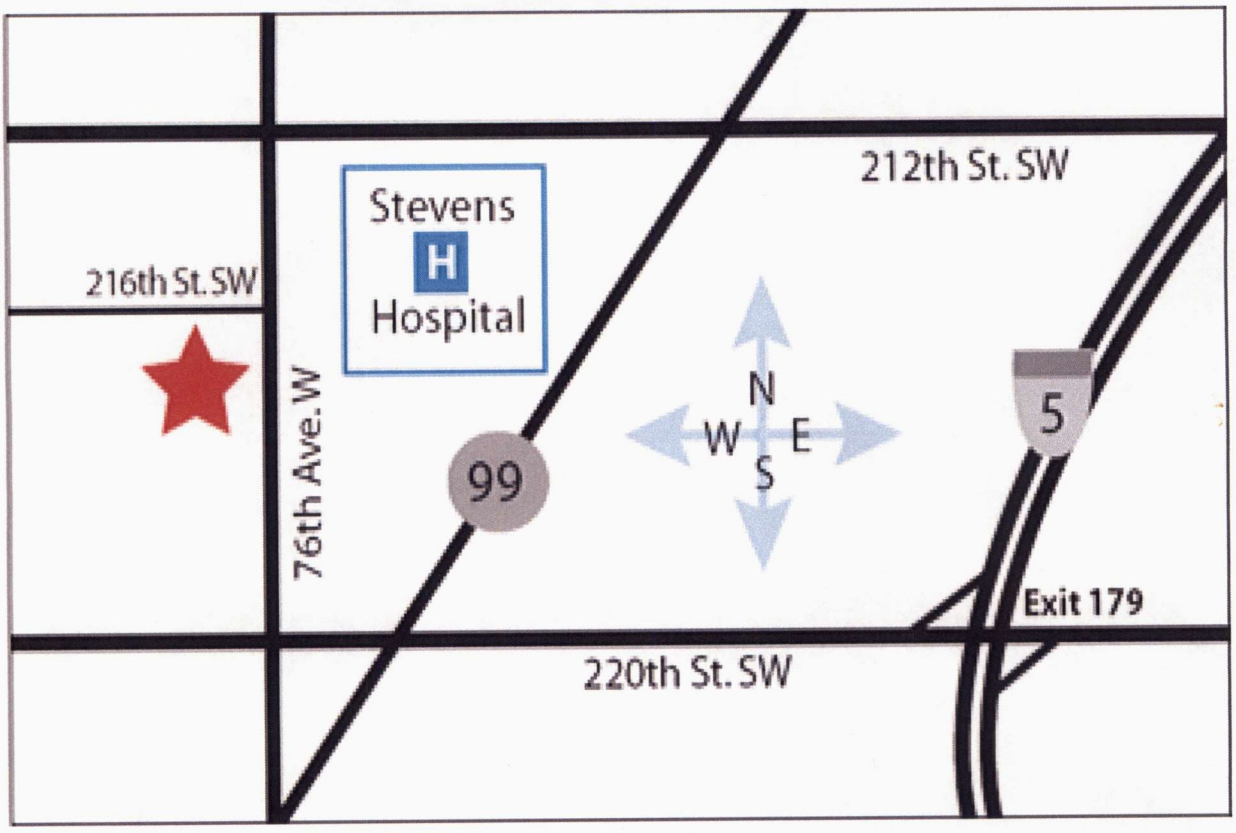
In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. **Web site**

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.retinaeyec.com**

7. **Effective date**

This Notice is effective as of 9/23/13



Take exit 179 from I-5
Head west on 220th St. SW
Turn right on 76th Ave W
Turn left onto 216th St. SW into parking lot
Parking is free
Suite 104 is on the 1st floor of Edmonds Medical Plaza
Across the street from Swedish/Stevens Hospital