RETINA ASSOCIATES, P.A.

Fred H Lambrou, Jr., M.D.
Mansoor Mughal, M.D.

Diseases and Surgery of the Retina, Macula and Vitreous

Name: ____

Address: ______________________________ Apt/Unit: __________

City, State & Zip Code: ______________________________

Date of Birth: ______________ Social Security Number: ________________

Home Phone: ________________ Cell Phone: ____________________

Work Phone: ________________ Email: ______________________

Gender: ________________ Preferred Language: __________________

Single ______ Married ______ Divorced ______ Widowed ______ Other ______

Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not-Hispanic or Latino ☐ Unknown ☐ Declined

Pharmacy Name: ____

Pharmacy Address & Phone: __________________________________

Emergency Contact(s):

Name of Person	Relationship to Patient	Phone
Name of Person	Relationship to Patient	Phone

If patient is a minor:

Name of Parent/Guardian	Relationship to Patient	Phone
Name of Parent/Guardian	Relationship to Patient	Phone

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Insurance Information:

Primary Insurance ______________________ Policy Number ______________________

Subscriber Name ______________________ Relationship to Patient ______________________

Subscriber's DOB ______________________ Subscriber's SSN ______________________

Secondary Insurance ______________________ Policy Number ______________________

Subscriber Name ______________________ Relationship to Patient ______________________

Subscriber's DOB ______________________ Subscriber's SSN ______________________

I hereby authorize my insurance benefit to be paid directly to Retina Associates, P.A. for any services furnished to me. I acknowledge financial responsibility for non-covered services. I also authorize the physician to release any information required to process this claim.

Patient's Signature ______________________ Date ______________________

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Lifetime Signature Authorization for Medicare

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize medical or other information about me to be released to the Social Security Administration, its intermediaries, or its carriers in order to process this Medicare claim. I request that payment of authorized benefits be made on my behalf to the physician.

Patient's Signature ______________________________ Date ______________

MEDIGAP Assignment

(Sign this is if you have a Secondary Insurance)

I request that payment of authorized MEDIGAP benefit be made on my behalf to Retina Associates, P.A. for any services furnished to me by Retina Associates, P.A. I authorize any holder of medical information about me to release to my supplemental carrier any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient's Signature ______________________________ Date ______________

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Informed Consent for Dilation

Dilating drops are used to enlarge the pupils of your eyes. This allows Dr. Fred H Lambrou, Jr. and Dr. Mansoor Mughal to get a better view the inside of your eye(s).

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 the physician or staff of Retina Associates, P.A. 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.**

Adverse reaction, 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 Dr. Fred H Lambrou, Jr., Dr. Mansoor Mughal and/or the staff of Retina Associates, P.A. to administer dilating eye drops as the eye drops are necessary to diagnose my condition.

Patient Signature ______________________________ Date ______________

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Release of Information

I authorize Dr. Fred H Lambrou, Jr., Dr. Mansoor Mughal and the staff of Retina Associates, P.A. to release information concerning the status of my health care, information about findings resulting from my eye exam(s), my plan of treatment, as well as billing and appointment information with:

______________________________	______________________________
Referring Physician	Office Phone
______________________________	______________________________
Primary Care Physician	Office Phone
______________________________	______________________________
Name of Person	Relationship to Patient
______________________________	______________________________
Name of Person	Relationship to Patient
______________________________	______________________________
Name of Person	Relationship to Patient
______________________________	______________________________
Name of Person	Relationship to Patient
______________________________	______________________________
Name of Person	Relationship to Patient

Patient or Guardian's Signature ______________________________ Date ______________

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Acknowledgement and Receipt of Notice of Privacy Practices

I have received a copy of Retina Associates, P.A.'s Notice of Privacy Practices effective September 23, 2013.

Name (please print) ______________________________

Signature ______________________________ Date ______________

OR If the patient is a minor:

I am a parent or legal guardian of ______________________ (patient name). I have received a copy of Retina Associates, P.A.'s Notice of Privacy Practices effective September 23, 2013.

Name (please print) ______________________________

Relationship to Patient ☐ Parent ☐ Legal Guardian

Signature ______________________________ Date ______________

Office Use Only

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on: ______________
Date

☐ In Person ☐ By Mail ☐ Other ______________________________

Reason individual or parent/guardian did NOT sign this form:

☐ Refused

☐ Did NOT respond after more than one attempt

☐ Other ______________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In-Person Conversation ______________________________

☐ Telephone Contact ______________________________

☐ By Mail ______________________________

☐ Other ______________________________

Staff Name (print) ______________________________ Position/Title ______________

Signature ______________________________ Date ______________

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NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of September 23, 2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer, Kelli Hurley, Practice Administrator (at 2 Shircliff Way, Suite 715, Jacksonville, FL 32204, phone 904.388.8446) with any questions, comments, or complaints or to exercise any of your rights.