Name:
DOB:
Chart:
Age:
Date:

Retina-Vitreous Associates Medical Group

- ☐ David S. Boyer, MD, Inc
- ☐ Roger L. Novack, MD, PhD, F.A.C.S.
- ☐ Thomas G. Chu, MD, PhD, Inc
- ☐ Firas M. Rahhal, MD, Inc.
- ☐ Homayoun Tabandeh, MD, MS, FRCP, FRCOphth
- ☐ Richard H. Roe, MD, M.H.S.
- ☐ Pouya N. Dayani, MD, Inc
- ☐ David S. Liao, MD, PhD
- ☐ Daniel D. Esmaili, MD
- ☐ Jeffrey J. Tan, MD
- ☐ Alexander C. Walsh, MD

○ Los Angeles ○ Beverly Hills ○ North Hollywood ○ Torrance ○ Pasadena ○ Tarzana

Doctor:

Location:

Dear Patient,

Welcome.

You have been referred for a retinal consultation. The evaluation and treatment of the retina is a complicated and thorough process. Like you, patients who are being seen here today have equally complex retinal diseases. Some patients may have also been added into our schedule on an emergency basis.

All our patients are important to us and we will do our utmost to provide you with the best possible care. Medical history review, vision testing, dilation, and examination by the staff and the physician usually takes two (2) hours. In some cases, specialized tests and procedures may further lengthen your appointment.

We know your time is valuable and we appreciate your patience.

Sincerely,

The Doctors and Staff at Retina-Vitreous Associates Medical Group

I acknowledge that I have read the above and understand that my examination may take two hours or longer to complete.

NOTICE TO PATIENTS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov

Patient Signature _____ *Date* ____ / ____ / ____

Name:
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Doctor:

Location:

Notice of Privacy Practices
Privacy Committee
(213) 483-8810

Effective Date: April 14, 2003

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy of privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed _____ Date _____

Printed Name _____

If not signed by the patient, please indicate the relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient:

Name:
DOB:
Chart:
Age:
Date:

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Doctor:
Location:

Insurance Billing

I hereby authorize the doctor whose name appears above to furnish my insurance company all information which the insurance company may request concerning my present illness or injury.

I hereby assign to the doctor whose name appears above all the money to which I am entitled for medical and/or surgical expense relative to the service reported above. I understand that I am financially responsible to said doctor(s) for charges not covered by this assignment.

SIGNATURE _____ PATIENT _____ DATE _____

NO INSURANCE: Payment is due at the time of service; however, we do allow financial arrangements. Non-paid accounts are referred to a collection agency ninety (90) days after the first charge.

INSURANCE: Co-payments, deductibles, or non-covered charges are due at the time of service. Non-paid accounts are referred to a collection agency one hundred and twenty (120) days after the first charge. We may bill your insurance for you; however, this does not release your responsibility for payment on any charges not paid by your insurance.

Name:
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Date:

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Doctor:

Location:

PLEASE PRINT AND COMPLETE TO THE BEST OF YOUR ABILITY RV Account # _____

Date Today _____ Patient Name _____
Last *First* *Middle Initial*

Birth Date _____ □ Male □ Female Social Security # ___ - ___ - ____

If patient is minor, name & contact information of responsible parent _____
Last *First*

Home Address _____ City _____ State _____
Street *Apt No.*

Zip Code _____ Home Phone _____ Cell Phone _____

Daytime Phone _____ Email _____ .com

Occupation _____ Employer _____ Phone _____

Referring Doctor and Primary Care Physician

Patient Referred By _____ City _____ Phone _____

Address (if known) _____
Street *Suite No.*

Primary Care Doctor _____ City _____ Phone _____

Address (if known) _____
Street *Suite No.*

Emergency Contact Information

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

If patient lives in nursing facility, name of facility _____

Facility Address _____
Street *Room No.*

City _____ State _____ Zip Code _____ Phone _____

PLEASE SUBMIT INSURANCE CARDS, CLAIM FORMS

AND/OR AUTHORIZATION FORMS

Name:
DOB:
Chart:
Age:
Date:

Doctor:
Location:

Consent For E-mail Communication

Email: _____ @ _____

I hereby consent to e-mail communication between myself and Retina-Vitreous Associates Medical Group for the explicit purpose of receiving login instructions and information for the online patient portal.

The online patient portal is a secure website through which Retina-Vitreous Associates Medical Group can communicate with patients who have created accounts. The Center for Medicare & Medicaid Services (CMS) has mandated that healthcare professionals providing services to Medicare and Medicaid patients must provide patients with the ability to view online patient health information.

I also consent to informational e-mails and non-patient specific reminders. E-mail will never be used for communications regarding patient identifiable medical or financial issues.

I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or the patient portal.

Retina-Vitreous Associates Medical Group will not sell or distribute e-mails to third parties for commercial or marketing purposes.

☐ Consent ☐ Decline

Signature _____ Date _____

Consent For Use of Electronic Prescription Information

I agree that Retina-Vitreous Associates Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for medical care and treatment purposes.

☐ Consent ☐ Decline

Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

LANGUAGE, RACE, ETHNICITY QUESTIONNAIRE

This information is being requested by the federal government and will not be shared for non-medical use.
You are free to decline disclosure of this information.

PREFERRED LANGUAGE	
☐ Arabic	☐ Armenian
☐ Chinese	☐ English
☐ Korean	☐ French
☐ French Creole	☐ Polish
☐ Persian	☐ Portuguese
☐ German	☐ Russian
☐ Greek	☐ Spanish
☐ Gujarati	☐ Tagalog
☐ Hebrew	☐ Urdu
☐ Hindi	☐ Vietnamese
☐ Italian	

RACE
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

☐ I DECLINE TO DISCLOSE THE ABOVE INFORMATION

Name:
DOB:
Chart:
Age:
Date:

Doctor:
Location:
Retina-Vitreous Associates Medical Group New Consult

NAME _____ DATE _____ RV# _____ AGE _____

MEDICAL HISTORY QUESTIONNAIRE -- REVIEW OF SYSTEMS page 1 of 2

Date of **Birth** _____ Date of **last eye exam** _____

Do you have allergies to any medications? **YES** **NO**

If YES, list the medications and reactions: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, cancer, heart attack, etc.) or injuries (concussion, etc.): _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): _____

if you have ever been hospitalized, list date(s) and reason(s): _____

Do you ***currently*** have any problems in the following areas?

If YES, please provide information.	**YES**	**NO**	**Details**
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, chest pain, exercise intolerance, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, cough - productive/blood, asthma, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.)			

Name:
DOB:
Chart:
Age:
Date:

Retina-Vitreous Associates Medical Group New Consult

NAME _____ DATE _____ RV# _____ AGE _____

MEDICAL HISTORY QUESTIONNAIRE -- REVIEW OF SYSTEMS page 2 of 2

(continued) Do you ***currently*** have any problems in the following areas?

If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, burning, impotence, incontinence, infections, etc.)			
MUSCLES, BONES, JOINTS (muscle pain/cramps, joint pain swelling, stiffness, etc.)			
SKIN (itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.)			
NEUROLOGICAL (numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.)			
PSYCHIATRIC (depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.)			
ENDOCRINE (diabetes, thyroid problems, fatigue, hair loss. hot/cold intolerance, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, blood disorders, leukemia, prolonged bleeding, etc.)			
ALLERGIC / IMMUNOLOGIC (recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc.)			

FAMILY HISTORY OF EYE DISEASE? YES / NO

_____ GLAUCOMA	_____ MACULAR DEGENERATION
_____ CATARACT	_____ MACULAR DYSTROPHY
_____ RETINAL DETACHMENT	_____ RETINITIS PIGMENTOSA
_____ BLINDNESS	_____ RETINAL DEGENERATION

FAMILY HISTORY OF SYSTEMIC ILLNESS? YES / NO

_____ DIABETES	_____ HYPERTENSION
_____ CANCER	_____ ARTHRITIS
_____ HEART DISEASE	_____ OTHER:

SOCIAL HISTORY? YES / NO

_____ SMOKING - if so, how many packs per day?_____ how many years?_____

_____ ALCOHOL _____ ILLICIT DRUGs

This form was completed by:
☐ *Patient* ☐ *Family* ☐ *Technician*
Signature of Technician _____

REVIEWED BY:
Physician's Signature _____ *Date* _____