

Macular Research Institute
Retina & Vitreous
CENTER_{PC}

William S. Rodden, M.D.
Christine R. Gonzales, M.D.
John D. Hyatt, M.D.
Joshua S. Agranat, M.D.

Patient Name (PLEASE PRINT): _____ **Date of Birth:** _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY INFORMATION

The Retina & Vitreous Center of Southern Oregon, PC's "Notice of Privacy Practices" contains information about the uses and disclosures of your protected health information.

Because we reserve the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may also change. An updated **Notice** will be posted in the lobby of our office indicating the effective date of the Notice in the lower right-hand corner. You will be offered a copy of the updated **Notice** on your first visit to our office after the effective date of the updated **Notice**. We will also provide you with a copy of the **Notice** upon your request.

I have reviewed the Retina & Vitreous Center of Southern Oregon, PC's **Notice of Privacy Practices**, and a copy of the **Notice** has been made available to me.

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

As more fully explained in the above **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request, unless the information is needed to provide you with emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I authorize the Retina & Vitreous Center of Southern Oregon, PC to use and disclose my health and medical information for the purposes of treatment, payment, and health care operations.

I understand that I have the right to revoke this **Consent** provided I do so in writing, except to the extent that Retina & Vitreous Center of Southern Oregon, PC has already used or disclosed the information in reliance on this **Consent**.

Please check the appropriate box below

☐ I agree to the above consent to use or disclose medical information

Patient Signature

Date

OR

Person Authorized by Law
(PLEASE PRINT)

Signature / Relationship to Patient

Date

☐ I decline to consent to use or disclose medical information. In doing so, I understand that Retina & Vitreous Center of Southern Oregon, PC will be unable to bill my insurance and I will be considered a self-pay patient; balance due at time of service. _____ (Patient initial here)

Patient Signature

Date

OR

Person Authorized by Law
(PLEASE PRINT)

Signature / Relationship to Patient

Date

Macular Research Institute
Retina & Vitreous
CENTER_{PC}

William S. Rodden, M.D.
 Christine R. Gonzales, M.D.
 John D. Hyatt, M.D.
 Joshua S. Agranat, M.D.

Patient Name (PLEASE PRINT): _____ **Date of Birth:** _____

PATIENT COMMUNICATION / EMERGENCY CONTACT

It is the policy of Retina & Vitreous Center of Southern Oregon, PC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (i.e. if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate you will need or want your medical information to be provided to family members, friends or others, please indicate below so we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add or remove names at a later date, please notify our office.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date

OR

Person Authorized by Law
(PLEASE PRINT)

Signature / Relationship to Patient

Date

Alternative Communications: You are also entitled to specify alternative, reasonable means of communication if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:

Macular Research Institute
Retina  **Vitreous**
CENTER_{PC}

William S. Rodden, M.D.
Christine R. Gonzales, M.D.
John D. Hyatt, M.D.
Joshua S. Agranat, M.D.

Physicians and Surgeons • Practice limited to diseases and surgery of the macula, retina and vitreous

Financial Policies and Payment

Retina and Vitreous Center billing department is available by phone from 8 a.m.–5 p.m., Monday through Friday

We will bill your primary and secondary Medical insurance as a courtesy to you. Please help us by providing your current insurance cards at check-in. We are committed to helping you understand your medical insurance and our billing processes detailed below:

- ✧ *Co-payments are due at the time of service*
- ✧ *For surgical patients, deposits and payment arrangements are required prior to the date of surgery*
- ✧ *If you are uninsured and unable to pay in full at the time of service, please make payment arrangements with our Billing Department*
- ✧ *Unmet deductibles will require a deposit at time of service*
- ✧ *For Worker's Compensation claims, if your claim is not accepted by the carrier, you are responsible for all charges incurred*

Account balances over 30 days are considered past due and account balances over 90 days will be considered for alternative collection measures.

We realize that temporary financial issues may affect your timely payment. Please contact our Billing Department directly at 541-552-4055 to discuss options and how we can best assist you.

Patient Signature

Macular Research Institute
Retina & Vitreous
CENTER_{PC}

Christine R. Gonzales, M.D.
John D. Hyatt, M.D.
Joshua S. Agranat, M.D.

246 Catalina Drive, Suite 1, Ashland, OR 97520
Phone (541) 488-3192
Fax (541) 488-0646

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name _____

Date _____

Date of Birth _____

Telephone _____

Social Security No. _____

I authorize _____ to release a copy of my medical information to:

Retina & Vitreous Center of Southern Oregon
Dr. Christine R. Gonzales, Dr. John D. Hyatt and Dr. Joshua S. Agranat
Fax (541) 488-0646

We are requesting health information in the following records:

- ☐ Full Medical Records Including any Infections such as Hepatitis and HIV
- ☐ Limited Medical Records (Date range): _____
- ☐ Billing Records (Date range): _____
- ☐ Diagnostic Tests: _____
- ☐ Other _____

Reason for Request: _____

Signature of Patient or Guardian*

Print Name of Patient or Guardian

* If this request is being signed by an individual's personal representative, please state the basis for the representative's authority: _____ (e.g., state law, court order, etc.).

REGISTRATION INFORMATION: PLEASE FILL OUT

Welcome to our office. We are committed to providing you with the finest, most comprehensive care possible. All information is confidential and is only released with your written consent.

Today's Date _____

Name _____ Preferred (Nickname) _____

Social Security # _____ How did you hear about us? _____

Birth Date _____ Gender _____ Marital Status _____

Address _____
Street City State Zip Code

Mailing Address _____
Street / PO Box City State Zip Code

Home Phone () _____ Cell Phone () _____

Appointment Reminder (Please circle) Phone Call / Text Message

Occupation / Employer _____ Business Phone () _____

Ophthalmologist (Eye MD) _____ Optometrist (OD) _____

Primary Care Physician _____ Phone () _____

Address _____
City State

Other Physicians _____

Preferred Language (Please circle one) English Spanish French German Italian Mandarin

Vietnamese Other _____

Race (Please circle one) Caucasian Hispanic/Latino Asian Native American or Alaskan Native

African American Japanese Native Hawaiian or Other Pacific Islander Undetermined Other _____

Ethnicity (Please circle one) Hispanic or Latino Non Hispanic or Latino

Primary Insurance _____

Secondary Insurance _____

Tertiary Insurance _____

Are you currently residing in a Skilled Nursing Facility? Yes _____ No _____

Is your visit related to a **work injury**? Yes _____ No _____ Date of Injury: _____

Is your visit related to an **auto accident**? Yes _____ No _____ Date of Accident: _____

Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Please list **Medication Allergies** and Reactions:

Ocular and Prescription Medications:

[illegible]

PLEASE CONTINUE FILLING OUT ON REVERSE

Patient Medication List (Continued): Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Over the Counter Medications:

Over the Counter Medication (Vitamins & Herbal Supplements)	Strength (mg, iu, ml, etc.)	Dosage	Frequency (# of times daily)	How Taken (oral, injection, etc.)

Medical History Questionnaire: Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Which of the following conditions are you currently being treated for or have been treated for in the past (please check):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Crohn's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Swollen ankles | |
| <input type="checkbox"/> Other: _____ | | | |

Please list your past ocular treatments: (Procedure, Date, Eye(s))

- ☐ Cataract Extraction Date? Which Eye(s)? _____
- ☐ Laser Date? Which Eye(s)? _____
- ☐ Injections Date? Which Eye(s)? _____
- ☐ Glaucoma Stent Date? Which Eye(s)? _____
- ☐ Lasik/Vision Correction Surgery Date? Which Eye(s)? _____
- ☐ Other Date? Which Eye(s)? _____

Please list your past ocular surgeries: (Procedure, Date, Eye(s))

- ☐ Retinal Detachment Date? Which Eye(s)? _____
- ☐ Macular Hole Date? Which Eye(s)? _____
- ☐ Epiretinal Membrane Date? Which Eye(s)? _____
- ☐ Other Date? Which Eye(s)? _____

Please list your other surgeries: (Procedure, Date)

Do you have or have you ever had:

- HIV / Aids? ☐ Yes ☐ No Other Active Infectious Diseases: _____
- Hepatitis A, B, or C? ☐ Yes ☐ No _____
- MRSA? ☐ Yes ☐ No _____
- Ocular Herpes? ☐ Yes ☐ No _____

Social and Preventive History:

Have you had a pneumonia vaccine? ☐ Yes ☐ No If yes, when? _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how often? _____ If no, have you in the past? ☐ Yes ☐ No

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Occasional

Any current recreational drug use? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

Medical History Questionnaire (Continued): Please Fill Out

Family History:

<input type="checkbox"/> Heart disease	Relation: _____	<input type="checkbox"/> Glaucoma	Relation: _____
<input type="checkbox"/> High cholesterol	Relation: _____	<input type="checkbox"/> Macular Degeneration	Relation: _____
<input type="checkbox"/> High blood pressure	Relation: _____	<input type="checkbox"/> Diabetic Retinopathy	Relation: _____
<input type="checkbox"/> Blood disorders	Relation: _____	<input type="checkbox"/> Vein Occlusions	Relation: _____
<input type="checkbox"/> Diabetes	Relation: _____	<input type="checkbox"/> Retinal Detachment / Tears	Relation: _____
<input type="checkbox"/> Cancer	Relation: _____	<input type="checkbox"/> Myopia	Relation: _____
<input type="checkbox"/> Thyroid disorders	Relation: _____	<input type="checkbox"/> Blindness	Relation: _____
<input type="checkbox"/> Other: _____			