ANGIOLETTI
RETINA

Welcome to Angioletti Retina! Our commitment is to provide you with an accurate assessment and evaluation coupled with immediate, early intervention and the best possible eye care in a compassionate and caring manner.

Enclosed you will find our new patient information forms. Please complete and submit all forms to our office staff prior to or at the time of your visit. **Also, please be sure to bring your insurance cards and required co-payment or deductibles (if any) to your appointment.**

Once again, welcome to Angioletti Retina. Should you have any questions, please do not hesitate to contact us at 212-691-4200.

Sincerely,

Nelson Co
Office Administrator

NEW PATIENT REGISTRATION FORM

First Name: MI: Last Name:		Suffix:	Sex: M / F
Home Address:			Date of Birth:
City:	State:	Zip Code:	
Preferred Language:			
Ethnicity: □ Hispanic Origin □ Not of Hispanic Origin	Race: □ American Indian or Alaskan Native □Black/African □ Asian □ Not of Hispanic Origin □Hispanic or Latino □ White		
Home #:	Work #:		Cell#:
Social Security #:	Marital Status: □S □M □D □W		E-mail:
Patients' Employer Name:	Address:		Occupation:
Emergency Contact Name:	Phone #		Relationship
Financially Responsible Person (If Different from patient):			Phone #
Responsible Person's Address:			
****Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?** □Yes □No			
If yes, name and address of facility:			Phone #

PATIENT MEDICAL QUESTIONNAIRE

Name: _____ Date of Birth: _____ Date: _____

- What is the eye problem that you believe needs to be addressed?

_____

_____

_____

_____

- Do you wear glasses? ____Yes ____No Contact Lenses? ____Yes ____No

  Referring Eye Doctor Name: _____

Address: _____

Phone Number: _____

Medications / Dietary / Herbal Supplements?

_____

_____

_____

_____

List Allergies or Reactions to Medications:

_____

_____

_____

_____

PATIENT MEDICAL QUESTIONNAIRE (Continued)

PAST MEDICAL HISTORY / CURRENT ILLNESSES (CHECK ALL THAT APPLY)

_____ Anemia

_____ Arthritis

_____ Asthma

_____ Bladder Disease

_____ Bleeding Tendencies

_____ Bronchitis

_____ Cancer

What Type: _____

_____ Cataracts

_____ Chicken Pox

_____ Dementia
(Memory Problems)

_____ Diabetes

_____ Emphysema

_____ Gallbladder Problems

_____ Glaucoma

_____ Heart Disease

_____ Hearing Loss

_____ Hepatitis □A □B □C

_____ High Blood Pressure

_____ HIV

_____ Mental Illness

_____ Influenza

_____ Jaundice

_____ Kidney Failure

_____ Kidney Stones

_____ Measles

_____ Hyperlipidemia
(High cholesterol or Triglycerides)

_____ Mumps

_____ Pregnant

Specify Due Date: _____

_____ Reflux

_____ Seizures

_____ Skin Lesions / Rash

_____ Sickle Cell Disease

_____ Stroke

_____ Tuberculosis

_____ Thyroid Disease

_____ Sexually Transmitted Disease

_____ Other

_____

_____

_____

_____

Operations / Hospitalizations:

_____

_____

_____

_____

Eye Treatment (Please indicate Eye, Date and if possible, drug):

_____

_____

_____

_____

PATIENT HABITS:	Present		Past		Amount
Tobacco (Cigarettes, Cigars, Chewing, Pipes)	□ Yes	□No	□ Yes	□No	_____
Alcohol	□ Yes	□No	□ Yes	□No	_____
Illicit Drugs	□ Yes	□No	□ Yes	□No	_____

Type of Drugs: _____

FAMILY HISTORY (Check those that a family member has had)

_____ Alzheimer's Disease	_____ Cancer	_____ Heart Problems
_____ ARMD	_____ Diabetes	_____ High Blood Pressure
_____ Asthma	_____ Epilepsy	_____ Kidney Disease
_____ Arthritis	_____ Glaucoma	_____ Retinal Disease
_____ Thyroid Disease	_____ Other: _____	

Please provide us with the names of your physicians so that we may send them a report.

Primary Care Physician's Name: _____

Address: _____

_____

Phone Number: _____

Cardiologist's Name: _____

Address: _____

_____

Phone Number: _____

Endocrinologist's Name: _____

Address: _____

_____

Phone Number: _____

Specialist's Name: _____

Address: _____

_____

Phone Number: _____

Pharmacy Name: _____

Address: _____

_____

Phone Number: _____

ANGIOLETTI
RETINA

Protected Health Information Release Form

Patient Name: _____ Date of Birth:_____

I acknowledge that Angioletti Retina has provided me with a copy of their Privacy Notice.

Signature: _____ Date:_____

I hereby authorize the following individual(s) full / partial disclosure of my medical records including: Diagnosis, Treatments, Billing Issues, Appointment Information and Prescriptions, in accordance with HIPAA regulations.

*Concerning matters of my health, I give permission to speak with:

Name of Person(s): _____ Relationship to Patient:_____

Name of Person(s): _____ Relationship to Patient:_____

Name of Person(s): _____ Relationship to Patient:_____

Name of Person(s): _____ Relationship to Patient:_____

Signature: _____ Date:_____

Witness: _____

***It is my responsibility to notify the office in writing if I no longer wish the individuals listed to have access to my records, or any other change to availability of my information.**

ANGIOLETTI
RETINA

Patient agreement of Office Policies

1. Please confirm at the front desk **ON EVERY VISIT** changes in the following:
    a. Address
    b. Phone Numbers (Home / Cell / Work Number)
    c. Insurance
    d. If currently residing in a Skilled Nursing Facility

2. It is important that you notify the front staff if you are currently residing in (or were recently discharged from) a Skilled Nursing Facility prior to treatment to receive written confirmation.

3. In order to expedite your time in the office, please come prepared with your referral (if required) and pay all payments prior to being seen. Payments may consist of co-pays, deductibles and co-insurance payments depending on your insurance coverage.

4. Please be aware that insurance companies authorize referral visits two ways:
    a. They issue a number of visits.
    b. They issue a time frame. If visits are not utilized within the time frame you are given, the visits will expire and you're responsible to know how many visits you have and when the time frame is up.

5. We will utilize your insurance based upon your policy provisions. However, the ultimate responsibility rests on the patient.

6. Any and all diagnostic testing should **NEVER** be missed. Test results are vital to your doctor's ability to determine the appropriate treatment plan for you.

7. Food and drink are not permitted in the office. Please help keep our office clean.

Patient Name: _____

Signature: _____ Date_____

Angioletti Retina Financial Policies

Patient Name: _____ Date of Birth:_____

1. **Assignment and Release:** I, the undersigned, certify that I (or my dependent) have insurance coverage and assign to Angioletti Retina all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize Angioletti Retina to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

   Signature: _____ Date: _____

2. **Cancellation Policy:** I, the undersigned, understand that as a patient at Angioletti Retina I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a $25 cancellation fee.

   Signature: _____ Date: _____

3. **Medicare Patients:** If you are covered by Medicare, please read and sign the following: In Medicare cases, Angioletti Retina agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of Medicare.

4. **Co-Payments and Co-Insurance:** Co-payments and co-insurance must be paid at each visit according to your insurance contract. **Patients with GHI and Empire coverage are also responsible for diagnostic co-pays.** We do perform diagnostic tests and co-pays will be collected at time of check out. Please plan accordingly. We accept cash, check, and credit cards (Visa, Master Card, American Express, or Discover).

5. **Worker' Compensation Only:** You may become responsible for medical costs of treatment for your illness or condition with Dr. Angioletti if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a cause of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and an approved pursuant to Workers' Compensation #32 in which you waive your right to medical benefits from the workers' compensation carrier/self insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

   Patient/Guardian Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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 clearly.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information to raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests, work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

HIPAA Notice of Privacy Practices (Continued)

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
- We may say “no” to your request, but we’ll tell you why in writing within 60 days

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
- We will say “yes” to all reasonable requests

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why
- We will include all the discloses except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

HIPAA Notice of Privacy Practices (Continued)

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- We will make sure the person has this authority and can act for you before we take any action

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy notes

In the case of fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

HIPAA Notice of Privacy Practices (Continued)

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat You

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

HIPAA Notice of Privacy Practices (Continued)

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by the law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will never sell personal information. We will not market personal information without your consent.

For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective: 10/01/2018
Privacy Officer: nelson@angiolettiretinanyc.com