THE RETINA GROUP, INC
262 NEIL AVENUE, SUITE 220
COLUMBUS, OHIO 43215

CHIRAG C. PATEL, MD
CHRISTIANE K. HUNT, DO
MATTHEW J. BYUN, MD
MASHAL AKHTER, MD

PHONE: 614-464-3937
800-824-6320
FAX: 614-464-0088
WWW.THERETINAGROUP.COM

THE EYE CENTER ■ COLUMBUS EAST ■ DELAWARE ■ ZANESVILLE ■ LANCASTER

NEW PATIENT INFORMATION

Date: ____________________ Address: ____________________

Last Name: ____________________ City, State/Zip: ____________________

First Name: ____________________ Day Phone: ____________________

Date of Birth: ____________________ Cell Phone: ____________________

Social Security #: ____________________ Email: ____________________

Ethnicity: ____________________ Race: ____________________

Religion: ____________________ Preferred Language: ____________________

EMERGENCY CONTACT INFORMATION

Last Name: ____________________ Address: ____________________

First Name: ____________________ City: ____________ State: ________

Relationship to Patient: ____________________ Zip Code: ________ Home Phone: ____________

Cell Phone: ____________________ Work Phone: ____________________

POA/LEGAL GUARDIAN INFORMATION (LEGAL DOCUMENTATION MUST BE PROVIDED)

Last Name: ____________________ Address: ____________________

First Name: ____________________ City: ____________ State: ________

Relationship to Patient: ____________________ Zip Code: ________ Home Phone: ____________

Cell Phone: ____________________ Work Phone: ____________________

PHYSICIAN INFORMATION

Primary Physician: ____________________ Referring Physician: ____________________

Address: ____________________ Address: ____________________

City: ____________ State: ________ City: ____________ State: ________

Zip Code: ________ Phone: ____________ Zip Code: ________ Phone: ____________

Fax: ____________________ Fax: ____________________

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INSURANCE COVERAGE INFORMATION

If your insurance coverage changes, it is your responsibility to notify our office. Failure to do so could result in denial of service(s) rendered to you and may leave you financially responsible.

****If you are not the Policy/Member holder and are a dependent on the plan please provide the Members information below.**

PRIMARY INSURANCE:

1) Insurance Company Name: ______________________________
2) Member ID Number: ______________________________
3) Group Number: ______________________________
4) Members Name: ______________________________
5) Date of birth: ______________________________
6) Social Security Number (if permission is given): ______________________________

SECONDARY INSURANCE (IF APPLICABLE):

1) Insurance Company Name: ______________________________
2) Member ID Number: ______________________________
3) Group Number: ______________________________
4) Members Name: ______________________________
5) Date of birth: ______________________________
6) Social Security Number (if permission is given): ______________________________

TERTIARY INSURANCE (IF APPLICABLE):

1) Insurance Company Name: ______________________________
2) Member ID Number: ______________________________
3) Group Number: ______________________________
4) Members Name: ______________________________
5) Date of birth: ______________________________
6) Social Security Number (if permission is given): ______________________________

By signing below, I authorize The Retina Group, Inc. to release any Medical information necessary for insurance claim submission, and request that Medical Benefit payment be made directly to The Retina Group, Inc. for services rendered.

Patient/Guardian Signature: ______________________________ Date: ______________

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PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   A. Bring your insurance card(s) to every visit and make us aware of any changes in your coverage.
   B. ***Copays and outstanding balances will be collected before you are seen by our clinical staff.*** Payment can be made by Cash, Check, Credit Card, or CareCredit. We are required by your insurer to collect your portion for the services you receive.
   C. For medical care not covered under your insurance, payment in full is due at the time of the visit.
2. If you have an insurance that we do not participate in, our office is happy to file the claim upon request. However, payment in full is expected at the time of service. This also applies to uninsured patients.
3. It is your responsibility to obtain required referrals or authorizations for treatment prior to your visit. If you do not have the referral or authorization, your visit may be rescheduled in non-emergency circumstances or you may be financially responsible.
4. If the patient is a minor (*under the age of 18*), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for payments due at the time of service, providing necessary referrals, authorizations, and insurance card(s). If a parent is responsible for any balances, we will ultimately rely upon the parent who brought the child to the office as being financially responsible.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (this number can be found on your card).
6. If you fail to make payment in full for services that are rendered to you, your outstanding balance may be reviewed for collections. You will be responsible for fees assessed by collection agency.

Questions about financial arrangements should be directed to our billing department at: (614) 464-3937.
Please sign that you have read and agree to this Financial Policy.

X ______________________________ ______________
Signature of Patient or Responsible Party Date

______________________________ ______________
Signature of Co-Responsible Party Date

APPEAL REPRESENTATIVE FORM

Member Name: ______________________ Member DOB: ______________

Insurance Company: ______________________ Member ID Number: ______________

I, ______________________, appoint The Retina Group, Inc. to act as my representative in requesting appeals from my health insurance company regarding the termination, reduction, denial, underpayment, or suspension of medical service coverage.

X ______________________________ ______________
Signature of Patient or Authorized Representative Date

______________________________ ______________
Print Name of Individual's Representative (if applicable) Relationship

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HIPAA - CONSENT

Patient Name: ______________________________ DOB: ______________

The Retina Group has my permission to speak with:

______________________ Relationship to Patient: ______________________

______________________ Relationship to Patient: ______________________

______________________ Relationship to Patient: ______________________

______________________ Relationship to Patient: ______________________

** Anyone with POWER OF ATTORNEY must provide TRG with a copy for the patient's chart.

Check One:

- ☐ About my medical condition
- ☐ About my financial information
- ☐ About my medical condition and financial information

AND

I acknowledge that I have received a copy of The Retina Group HIPAA Notice of Privacy Practices.

______________________________________ Date: ______________

Patient Signature

OR

The Retina Group does not have my permission to speak with anyone but myself about my medical condition and financial information.

AND

I acknowledge that I have received a copy of The Retina Group HIPAA Notice of Privacy Practices.

______________________________________ Date: ______________

Patient Signature

POS Reorder # 2217544

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name:______________________ DOB:__________ Date:__________

PRESENT OCULAR COMPLAINTS

	Yes	No		Yes	No
Distorted Vision	☐	☐	Burning/Itching/Tearing	☐	☐
Sudden Loss of Vision	☐	☐	Glare or Light Sensitivity	☐	☐
Loss of Side Vision	☐	☐	Eye Pain/Soreness/Tenderness	☐	☐
Double Vision	☐	☐	Flashes/Floaters/Veil/Curtain	☐	☐
Other__________	☐	☐	Other__________	☐	☐

FAMILY MEDICAL HISTORY

	Yes	No	Relationship		Yes	No	Relationship
Arthritis	☐	☐	________	Hypertension	☐	☐	________
Cancer	☐	☐	________	Kidney Disease	☐	☐	________
Diabetes	☐	☐	________	Lupus	☐	☐	________
Heart Disease	☐	☐	________	Thyroid Disease	☐	☐	________
Tuberculosis	☐	☐	________	Other__________			________

FAMILY OCULAR HISTORY

	Yes	No		Yes	No	
Blindness	☐	☐	Macular Degeneration	☐	☐	Other__________
Glaucoma	☐	☐	Retinal Detachment	☐	☐	Other__________

LIST OF EYE DROPS AND MEDICATIONS

________	________	________
________	________	________
________	________	________

EYE SURGERY HISTORY

Procedure	Date	Physician Who Performed
________	________	________
________	________	________
________	________	________

ALL OTHER SURGERIES AND HOSPITALIZATIONS (WITH DATES)

________	________	________
________	________	________
________	________	________

POS Reorder # 2217545

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MEDICATION ALLERGIES AND SENSITIVITIES

_______________ _______________ _______________

_______________ _______________ _______________

Do you have an allergy or sensitivity to latex? Yes ☐ No ☐

**IF you have been tested, please list date and lab: _______________

Do you have any allergy or sensitivity to adhesive tape? Yes ☐ No ☐

Is paper tape OK? Yes ☐ No ☐

MEDICATION LIST

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

SOCIAL HISTORY

Current Occupation: _______________

Do you drink alcohol? Yes ☐ No ☐

If yes, frequency: __________ quantity: __________

Do you smoke tobacco products? Yes ☐ No ☐

If yes, how much per day? __________

How many years? __________

GENERAL MEDICAL HISTORY

(Circle specific diagnosis)	Yes	No
CANCER	☐	☐
Type/Part of Body/Date of diagnosis & treatment		
_______________		
_______________		
CARDIOVASCULAR	☐	☐
(Heart attack, angina, congestive heart failure, irregular beat, defibrillator, pacemaker, stroke, stent)		
ENDOCRINE/DIABETES	☐	☐
How Long _______________		
Insulin dependent/ how long? _______________		
Last Blood Sugar __________ Last A1C __________		
EARS, NOSE, THROAT	☐	☐
(Hearing difficulty, ringing, sore throat, sinusitis)		
GASTROINTESTINAL	☐	☐
(Heartburn, nausea, vomiting, diarrhea, stomach ulcer Crohn's disease, colon cancer)		
HEPATITIS A, B, OR C	☐	☐
HIV (AIDS)	☐	☐
HIGH BLOOD PRESSURE	☐	☐
How Long _______________		
Last Blood Pressure _______________		
Is it Controlled _______________		
OTHER _______________		

(Circle specific diagnosis)	Yes	No
KIDNEY PROBLEMS	☐	☐
(Stones, kidney failure, blood in urine, dialysis)		
MRSA	☐	☐
(Methicillin-Resistent Staphylococcus Aureus)		
MUSCULOSKELETAL PROBLEMS	☐	☐
(Arthritis, muscle aches, joints, osteoporosis)		
NEUROLOGICAL	☐	☐
(Numbness, weakness, neuropathy, Multiple Sclerosis, restless leg syndrome, Parkinson's)		
PREGNANT (CURRENTLY)	☐	☐
PSYCHIATRIC	☐	☐
(Depression, anxiety, bipolar)		
RESPIRATORY PROBLEMS	☐	☐
(Asthma, emphysema, oxygen use, shortness of breath, cough, wheezing, sleep apnea)		
Tuberculosis, treatment date _______________		
SEXUALLY TRANSMITTED DISEASES	☐	☐
Dates of Treatment: from __________ to __________		
SKIN PROBLEMS	☐	☐
(Psoriasis, eczema, basal cell, vitiligo)		
THYROID PROBLEMS	☐	☐
(goiter, overactive, underactive)		
OTHER _______________		

POS Reorder # 2217546