

*** Please complete ALL forms using BLACK ink ***

Appointment Date	 Appointment Time	
Scheduled with Dr.	 Office Location	

Dear New Patient,

We appreciate your selection of our office for the care of your retinal (eye) condition. First visits to our office usually take approximately two to three hours. Dilation of your eyes will be required for the examination. Since the effect of this procedure can take a few hours to wear off, you will not be able to drive home afterwards. Therefore, we require that you arrange for other means of transportation to return home following your appointment. Please bring someone to drive you home or plan alternate arrangements.

Prior to your appointment, please fill in the new patient forms attached. Either bring these forms with you to your appointment, or plan to arrive at least twenty minutes before your scheduled appointment time to complete them in our office. Also, please bring a list of any medications and eye drops that you are currently using, along with your eyeglasses or contact lenses. Be sure you have all of your insurance cards and a current driver's license or other photo identification with you when you come to the office. We will ask for these cards and will keep a copy of each in our medical record.

We will file Medicare, Medicaid, Blue Cross, Blue Advantage, Aetna, Cigna, HealthSpring, United HealthCare, Viva, and all other insurances for you. Applicable co-payments will be collected from you for all insurance plans with which we participate. Payment is requested at the time of the office visit for any co-payments or non-insurance service and may be made in cash or by check or credit card. If you have not met your annual insurance deductible, all or a portion of that amount will be required at your visit as well.

If your insurance company requires that you get a referral (permission to be treated by one of our doctors), you are responsible for contacting your primary care physician (family doctor) before you come to our office. We suggest you call your primary care physician as soon as an appointment date has been set.

If you do not have health insurance, please contact our Billing Office at (205)329-7100 or (800)575-4315 at least TWO business days prior to your scheduled appointment to discuss payment options for our services.

We look forward to seeing you. If you have any questions regarding your appointment, please call us at (205)918-0047 or (800)575-4314. For billing and/or insurance information, please contact one of our Billing Office Representatives at (205)329-7100 or (800)575-4315. Thank you for your confidence in allowing us to participate in your retina care. We look forward to meeting you soon.

Most sincerely,

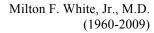
The Physicians and Staff of Retina Consultants of Alabama, P.C.



Account Number

1-800-575-4314

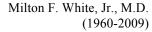
	Today S D	ate		
Patient Name			□Male	□Female
Address				
City Star		Lip Code		
Phone: Home () Work (Work () Cobama to leave messages for me co	ell (<u>)</u> incerning my appoir	ntments an	d eye care.
If Nursing Home/Assisted Living/Rehab resid	dent, Name of Facility			
Facility Phone: ()	Room Nu	ımber		
Social Security Number	Patient's Date of	Birth		
Employment □Full-Time □Part-Time □Not I	Employed □Retired □Mi	nor/Child		
If employed, Place of Employment	Occupation	on		
Type(s) of Insurance				
Marital Status □Single □Divorced □Widow	ed Married			
If married, Spouse's Name	Spouse's I	Date of Birth		
If patient is a minor, Mother's Name	Mother's I	Date of Birth		
Father's Name	Father's D	ate of Birth		
Legal Guardian's Name		ip		
(if different than Mother or Father)				
EMERGENCY CONTACTS (Persons NOT living in	your home; i.e. relatives or fri	ends)		
Jame	Relationshi	p		
Phone: Home () Work (Cel	11 ()		
Name	Relationshi	p		
Phone: Home () Work (
Referring Physician				
Person(s) to Whom Medical Information May Be Rel	leased			
Terson(s) to whom wedien information way be res				
1. Please remember that insurance is considered a method of reimbursing pay fixed allowances for certain procedures, and others pay a percentage other balance not paid for by your insurance at the time of your example.	of the charge. It is your responsibility to			
2. I request that payment of authorized Medicare and/or insurance beninformation about me to release to the Health Care Financing Administration benefits or the benefits payable for related services.				
3. This assignment will remain in effect until revoked by me in writing, understand that I am financially responsible for all charges whether or not of secure the payment. In the event of default in the payment of my charges.	ot paid by said insurance. I hereby author	ize said assignee to relea	se all inform	ation necessary
X				
X Patient's/Legal Guardian's Signature (must be 18 years)	ars of age or older)			Date





MEDICARE LIFETIME AUTHORIZATION

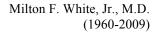
Patient's Name	
I request the payment of authorized Medicare benefits Consultants of Alabama, P.C. (Drs. Richard M. Feist, Jo Albert, Jr., and/or other affiliated physicians) for any se authorize any holder of medical information about me to agents, any information needed to determine these benefits	ohn O. Mason, III, Martin L. Thomley, Michael A. rvices furnished to me by that provider of care. It release to the Center of Medicare Services and its
X Patient's / Legal Guardian's Signature	Date





CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

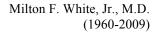
Patient Name Account Number
I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operation that may be used by the attending doctor, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of all services. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including a reasonable attorney's fee.
I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that my insurance will be submitted by this office and I will be responsible for paying all copays and/or deductibles at the time of visit.
I understand that if my insurance is an HMO, that I must obtain a referral from my Primary Care Physician every visit before coming to this office for any appointments. I understand that it is my responsibility as the patient to confirm that my referral is current and in effect when I arrive for my appointment. If no referral is obtained, I will pay for the visit.
I authorize my insurance company to remit payment of medical benefits directly to this office for services provided by our physicians.
I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.
X
Patient's / Legal Guardian's Signature Date





ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Patient Name	Account Number
I understand that Retina Consultants of Alabama is part providers may share my health information for treatmen. I have been given a copy of their Notice of Health information is used and shared. I understand that Retin notice at any time. I may obtain a current copy by contact	t, billing, healthcare operations, and research purposes. Information Practices that describes how my health a Consultants of Alabama has the right to change this
My signature below constitutes my acknowledgement Notice of Health Information Practices.	that I have been provided with a copy of the
X	





DILATING EYE DROPS

Patient Name	Account Number
Please read this important information carefully:	
Dilating eye drops are used to enlarge (dilate) the pupil of the view the inside of the eye and perform a thorough examination observed without the use of these drops.	
Dilating drops usually blur the vision for a length of time that and may make bright lights bothersome. It is not possible for be affected. Driving must be avoided immediately following the effects of the dilating drops have worn off.	your doctor to predict how much your vision will
By signing below, you acknowledge an understanding that di and EACH future appointment you may have at Retina Cons another person must be available at all visits to drive you hor	ultants of Alabama. Further, you understand that
X	Witness' (Staff Member's) Signature
Date	



1-800-575-4314

Patient Name:		
Date of Birth:	Age:	
Date:		

Ophthalmologist/Optometrist (eye):	umber) Primary Care (family):
((
Cardiologist (heart):	Other (i.e., Endocrinologist, etc.):
<u> </u>	<u> </u>
MACY	
Name:	
Location:	
Telephone: ()	
CATION List of medicines you take regularly and dosa ☐ See attached list	ages/schedule (including eye drops):
Allergies to medicines:	
Allergies to medicines: Type of reaction:	
Type of reaction:	e taking or have ever taken the following medications
Type of reaction: Please check YES or NO as to whether you are	e taking or have ever taken the following medications YES NO
Type of reaction:	YES NO



R'	RETINA CONSULTANTS of				
W	ĀLABAMA P.C.		Date		Age:
	1-800-575-4314			Date:	
PAST	EYE HISTORY (where appropriate, Known eye diseases:	, list da	ates and	which eye involved)	
	Previous eye operations/dates:				
	Previous eye injuries/dates:				
PAST	MEDICAL HISTORY				
	Medical Conditions	3.7	10	1 1 0	
	Diabetes Y	N N	If ye	s, how long?	
	High blood pressure Y Heart disease Y	N N	If wo	s, explain:	
			•	, 1	
	Other major illnesses (please list)				
	Previous surgeries (other than eye):				
FAMI	LY HISTORY (list blood relatives of	nly)	If Y I	ES, relationship to patien	t?
	· ·	• ,		mother, F=father, S=sibli	
	Retinal detachment	Y	N		
	Age-related macular degeneration	Y	N		
	Blindness	Y	N		
	Glaucoma	Y	N		
	Arthritis	Y	N		
	Cancer	Y	N		
	Diabetes	Y	N		
	Heart disease/high blood pressure	Y	N		
	Kidney disease	Y	N		
	Lupus	Y	N	-	
	Stroke	Y	N		
		-	- •	-	
SOCL	AL HISTORY				
	Occupation:				
	Marital status: □Single □Divor	rced	□Wide	owed Married	
	Special living arrangements:			Ambulatory with Assista	nce □Non-Ambulatory
		Y		amoulatory with Assista	nec Livon-Amountainy
	Do you dripk alcohol?	Y	N N	If VEC.	□1/dov. □2.2/dov. □4.1/dov
	Do you drink alcohol?		N N		$\Box 1/day \qquad \Box 2-3/day \qquad \Box 4+/day$
	Do you currently smoke?	Y	N		□½ pack/day □1+pack/day
	If NO, have you ever smoked?	Y	N	If YES : number of years?	when did you quit?
	Do you currently use smokeless				

Y

N

or other tobacco products?

If **YES**: number of years? _____



Patient Name: _	
Date of Birth: _	Age:
Date:	

1-800-575-4314

REVIEW OF SYSTEMS

Please check YES or NO as to whether you have ever had the following symptoms/problems.

OCRINE SYSTEM		YES	NO
Frequent urination, frequent	t thirst and hunger		
	Пр. 4.1 1 1. т.		
	□Diet plus oral medicine		
□Diet and insulin	Insulin type and dose Last hemoglobin A1C measurement and date		
Thyroid disease	Last hemoglobili ATC incastrement and date		
□Hypothyroid		··· <u></u>	
RT/BLOOD VESSELS			
Valvular heart disease		•••	-
Coronary artery disease		···	
Arrhythmia (irregular hearth	beat)	••	
Congestive heart failure		···	-
Difficulty breathing while a	t rest		
Chest pain on exertion		···	
Fluid accumulation in feet/a	ınkles		
Heart bypass surgery			-
Pacemaker			-
Defibrillator implant device			
Other heart problems, expla	.in		
Exercise tolerance	dentary only □2-3 flights of stairs		
ПNо	rmal activities \(\subseteq \text{Aerobic exercise} \)		
CER			
History of cancer		···	
Type			
Treatment			
VOUS SYSTEM			
~ .			
	t of the body		
	ing		-
			-
Generalized muscle weakne	SS	•••	-
History of anxiety or panic	attacks	•••	
History of schizophrenia		•• ———	-
		··· <u></u>	
E/JOINT			



Patient Name:	
Date of Birth:	Age:
Date:	

	1-800-575-4314		
RLOC	DD/LYMPH	YES	NO
DLOC	Anemia		
	Sickle cell disease.		
	Sickle cell trait.		
	Thalassemia		
	Hamaglahin C disassa		
	Hemoglobin C disease		
	Bleeding problems (free bleeder)		
	Other blood disorders, explain		
LUNC			
LUNG	GS/BREATHING		
	Active asthma		
	Asthma in the past		
	Productive cough within the last month		
	Chronic bronchitis Other breathing problems, explain		
	Other breathing problems, explain		
STOM	IACH/INTESTINES		
	Reflux from stomach		
	Ulcer disease		
	Liver disease		
	Hepatitis		
	History of nausea and vomiting		
	Gall bladder disease		
	Blood in vomit		
	Rectal bleeding		
ZIDN	ENZ/HIDINI A DNZ		
KIDN	EY/URINARY		
	Renal failure		
	On dialysis		
	Kidney transplant		
	Current urinary infection		
	History of kidney stones		
	History of blood in urine		
SKIN			
	History of skin cancer		
	Use of oral tanning agents		
	Use of oral retinoic acid for acne		
	Other skin problems, explain		
	other skin problems, explain	<u> </u>	
Techni	ician Signature	Physician Sig	gnature
		,	,
Date.			Date