RETINA CONSULTANTS of ALABAMA P.C.

Milton F. White, Jr., M.D.
(1960-2009)

Richard M. Feist, M.D.
John O. Mason, III, M.D.
Martin L. Thomley, M.D.
Michael A. Albert, Jr., M.D.

*** 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.

RETINA CONSULTANTS of ALABAMA P.C.

PATIENT DEMOGRAPHIC INFORMATION

1-800-575-4314

Account Number _____

Today's Date _____

Patient Name _____ ☐Male ☐Female

Address _____

City _____ State _____ Zip Code _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

☐ I authorize Retina Consultants of Alabama to leave messages for me concerning my appointments and eye care.

If Nursing Home/Assisted Living/Rehab resident, Name of Facility _____

Facility Phone: (____) _____ Room Number _____

Social Security Number _____ Patient's Date of Birth _____

Employment ☐Full-Time ☐Part-Time ☐Not Employed ☐Retired ☐Minor/Child

If employed, Place of Employment _____ Occupation _____

Type(s) of Insurance _____

Marital Status ☐Single ☐Divorced ☐Widowed ☐Married

If married, Spouse's Name _____ Spouse's Date of Birth _____

If patient is a minor, Mother's Name _____ Mother's Date of Birth _____

Father's Name _____ Father's Date of Birth _____

Legal Guardian's Name _____ Relationship _____
(if different than Mother or Father)

EMERGENCY CONTACTS (Persons NOT living in your home; i.e. relatives or friends)

Name _____ Relationship _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Name _____ Relationship _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Referring Physician _____

Person(s) to Whom Medical Information May Be Released _____

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance at the time of your examination.**

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. This assignment will remain in effect until revoked by me in writing. A photocopy or digital image of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. In the event of default in the payment of my charges, I agree to pay all costs of collections, including reasonable attorney's fees if applicable.

X _____ _____

Patient's/Legal Guardian's Signature *(must be 18 years of age or older)* *Date*

700 18th Street South • Suite 707 • Birmingham, Alabama 35233 • (205) 918-0047 • (800) 575-4314 • FAX (205) 918-0902

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MEDICARE LIFETIME AUTHORIZATION

Patient's Name *Account Number*

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Retina Consultants of Alabama, P.C. (Drs. Richard M. Feist, John O. Mason, III, Martin L. Thomley, Michael A. Albert, Jr., and/or other affiliated physicians) for any services furnished to me by that provider of care. I authorize any holder of medical information about me to release to the Center of Medicare Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

X

Patient's / Legal Guardian's Signature *Date*

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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*

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

_____ _____

Patient Name *Account Number*

I understand that Retina Consultants of Alabama is part of an organized healthcare arrangement, and that these providers may share my health information for treatment, billing, healthcare operations, and research purposes. I have been given a copy of their Notice of Health Information Practices that describes how my health information is used and shared. I understand that Retina Consultants of Alabama has the right to change this notice at any time. I may obtain a current copy by contacting the office.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

X_____ _____

Patient's/Legal Guardian's Signature *Date*

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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 eye to allow the ophthalmologist (eye doctor) to view the inside of the eye and perform a thorough examination of the retina. The retina cannot be completely observed without the use of these drops.

Dilating drops usually blur the vision for a length of time that varies from person to person (up to several hours) and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Driving must be avoided immediately following your examination and you should not drive until the effects of the dilating drops have worn off.

By signing below, you acknowledge an understanding that dilating drops will be used in your eyes at this visit and **EACH** future appointment you may have at Retina Consultants of Alabama. Further, you understand that another person must be available at all visits to drive you home.

X_____ _____

Patient's / Legal Guardian's Signature *Witness' (Staff Member's) Signature*

_____

Date

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RETINA CONSULTANTS of ALABAMA P.C.

1-800-575-4314

Patient Name: _____

Date of Birth: _____ *Age:* _____

Date: _____

MEDICAL INFORMATION

PHYSICIANS (name, address/location, telephone number)

Ophthalmologist/Optometrist (eye):

_____

_____

_____

( ) _____

Primary Care (family):

_____

_____

_____

( ) _____

Cardiologist (heart):

_____

_____

_____

( ) _____

Other (i.e., Endocrinologist, etc.):

_____

_____

_____

( ) _____

PHARMACY

Name: _____

Location: _____

Telephone: ( ) _____

MEDICATION

List of medicines you take regularly and dosages/schedule (including eye drops):

☐ See attached list

_____

_____

_____

Allergies to medicines: _____

Type of reaction: _____

Please check YES or NO as to whether you are taking or have ever taken the following medications.

	YES	NO
Plaquenil or Plaquenil Sulfate (hydroxychloroquine)	_____	_____
Soltamox (tamoxifen)	_____	_____
Mellaril (thioridazine)	_____	_____
Topamax, Topamax Sprinkle, or Topiragen (topiramate)	_____	_____

RICHARD M. FEIST, MD JOHN O. MASON, III, MD MARTIN L. THOMLEY, MD MICHAEL A. ALBERT, JR, MD

RETINA CONSULTANTS of ALABAMA P.C.
1-800-575-4314

Patient Name: _____

Date of Birth: _____ *Age:* _____

Date: _____

PAST EYE HISTORY (where appropriate, list dates and which eye involved)

Known eye diseases:

_____

Previous eye operations/dates:

_____

Previous eye injuries/dates:

_____

PAST MEDICAL HISTORY

Medical Conditions

Diabetes	Y	N	If yes, how long? _____
High blood pressure	Y	N	
Heart disease	Y	N	If yes, explain: _____

Other major illnesses (please list): _____

Previous surgeries (other than eye): _____

FAMILY HISTORY (list blood relatives only)

If **YES**, relationship to patient?
(M=mother, F=father, S=sibling, GP=grandparent)

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	_____

SOCIAL HISTORY

Occupation: _____

Marital status: ☐Single ☐Divorced ☐Widowed ☐Married

Special living arrangements: ☐Wheelchair ☐Ambulatory with Assistance ☐Non-Ambulatory

Do you drive?	Y	N	
Do you drink alcohol?	Y	N	If **YES**: ☐occasional ☐1/day ☐2-3/day ☐4+/day
Do you currently smoke?	Y	N	If **YES**: ☐occasional ☐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 or other tobacco products?	Y	N	If **YES**: number of years? _____

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Patient Name: _____

Date of Birth: _____ *Age:* _____

Date: _____

REVIEW OF SYSTEMS

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

	YES	NO
ENDOCRINE SYSTEM		
Frequent urination, frequent thirst and hunger……..	_____	_____
Diabetes mellitus……...	_____	_____
☐Diet-controlled ☐Diet plus oral medicine		
☐Diet and insulin Insulin type and dose _____		
Last hemoglobin A1C measurement and date _____		
Thyroid disease……..	_____	_____
☐Hypothyroid ☐Hyperthyroid		
HEART/BLOOD VESSELS		
Hypertension……..	_____	_____
Valvular heart disease……	_____	_____
Coronary artery disease……	_____	_____
Arrhythmia (irregular heartbeat)……...	_____	_____
Congestive heart failure……	_____	_____
Difficulty breathing while at rest……..	_____	_____
Chest pain on exertion……...	_____	_____
Fluid accumulation in feet/ankles……	_____	_____
Heart bypass surgery……..	_____	_____
Pacemaker……..	_____	_____
Defibrillator implant device……..	_____	_____
Other heart problems, explain _____	_____	_____
Exercise tolerance ☐Sedentary only ☐2-3 flights of stairs		
☐Normal activities ☐Aerobic exercise		
CANCER		
History of cancer……...	_____	_____
Type _____		
Treatment _____		
NERVOUS SYSTEM		
Stroke……	_____	_____
Temporary weakness of part of the body……..	_____	_____
Temporary difficulty speaking……..	_____	_____
Seizures……..	_____	_____
Generalized muscle weakness……	_____	_____
History of anxiety or panic attacks……	_____	_____
History of schizophrenia……	_____	_____
BONE/JOINT		
Chronic lower back pain……	_____	_____
Arthritis, type _____	_____	_____
Cervical spine diseases……..	_____	_____

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Date of Birth: _____ *Age:* _____

Date: _____

	YES	NO
BLOOD/LYMPH		
Anemia	_____	_____
Sickle cell disease	_____	_____
Sickle cell trait	_____	_____
Thalassemia	_____	_____
Hemoglobin C disease	_____	_____
Bleeding problems (free bleeder)	_____	_____
HIV	_____	_____
Other blood disorders, explain _____	_____	_____
LUNGS/BREATHING		
Active asthma	_____	_____
Asthma in the past	_____	_____
Productive cough within the last month	_____	_____
Chronic bronchitis	_____	_____
Other breathing problems, explain _____	_____	_____
STOMACH/INTESTINES		
Reflux from stomach	_____	_____
Ulcer disease	_____	_____
Liver disease	_____	_____
Hepatitis	_____	_____
History of nausea and vomiting	_____	_____
Gall bladder disease	_____	_____
Blood in vomit	_____	_____
Rectal bleeding	_____	_____
KIDNEY/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 _____	_____	_____

_____ _____

Technician Signature *Physician Signature*

_____ _____

Date *Date*

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