Macular Research Institute
Retina & Vitreous CENTER PC
William S. Rodden, M.D.
Christine R. Gonzales, M.D.
John D. Hyatt, 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**.

_____ _____

Patient Signature **Date**

OR

_____ _____ _____

Person Authorized by Law (PLEASE PRINT) | Signature / Relationship to Patient | Date

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) _____

Birth Date _____ Social Security Number _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street / PO Box City State Zip Code

Home Phone: (____) _____

Cell Phone (Important): (____) _____

Occupation / Employer: _____ Business Phone: (____) _____

Preferred Contact #: _____ Marital Status: _____

Email Address: _____

Referring Ophthalmologist (Eye MD) _____

Referring Optometrist (OD) _____

Primary Care Physician _____ Phone: (____) _____

Address _____
City State

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: _____

For Office Use Only:

☐ Email ☐ Referring Doctor
☐ Photo ☐ Verify Insurance

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Patient Medication List: Please Fill Out

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

Please list **Medication Allergies** and Reactions:

_____

_____

_____

_____

Ocular and Prescription Medications:

Ocular and Prescription Medications	Strength (mg, mcg, ml, etc.)	Dosage	Frequency (# of times daily)	How Taken (oral, injection, etc.)

PLEASE CONTINUE FILLING OUT ON REVERSE ☞

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PATIENT COMMUNICATION

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

FOR OFFICE USE: Changes to above authorized by patient over phone:

Change	Date	Staff Initials

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:

_____

_____

_____ _____

Patient Signature Date

OR

_____ _____ _____

Person Authorized by Law (PLEASE PRINT) Signature / Relationship to Patient Date

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):

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

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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 by calling 541-488-3192.

We will gladly bill your insurance as a courtesy to you. Please follow-up with them to make sure your account is paid. In addition, we will be happy to bill your secondary insurance carrier if you provide that information at the time of service.

We are here to assist you with any billing questions or problems you may have. Please help us by making sure that the reception staff has all of your updated insurance information.

- ***You will be required to make your co-pay and/or co-insurance at each visit. For those who have no insurance, you will be expected to pay your balance in full minus a 15% courtesy discount. For commercial plans, our policy is to collect your co-pay and the remaining balance (if any) when checking out after seeing the provider.***

Billing statements are mailed monthly. Account balances 90 days past due are considered delinquent. However, we realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance, otherwise, accounts over 90 days may be placed with our collection agency and your care with our practice may be terminated.

Financial Resources

Federal Poverty Guideline Sliding Fee Application

For those who may be experiencing financial hardship, sliding fees may be available to patients who have an annual combined household income that falls within the Federal Poverty Guidelines. Financial documentation is required.

_____ _____

Patient Signature Date

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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. William S. Rodden, Dr. Christine R. Gonzales and Dr. John D. Hyatt
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.).