NEWPORT RETINA
SHAHEM KAWJI, MD, INC

PATIENT INFORMATION

First Name _____ MI ____ Last Name _____ DOB _____ Age ____
Sex ____ SSN _____-____-_____ Email _____ Married? Y / N
Address_____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Primary Language _____
Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Referred by _____ ☐ Ophthalmologist ☐ Optometrist ☐ Primary Care Doctor

☐ Internet (☐Google ☐ Yelp ☐ Other _____)

*****If your insurance requires a referral from your primary care physician, please ensure we have received it.**

Your Preferred Pharmacy City State

If Patient is a Minor or Dependent

Name of Responsible Party _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Newport Retina & Macular Degeneration Center to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to Newport Retina & Macular Degeneration Center. I understand that I am financially responsible for ALL charges for services rendered to me by Newport Retina & Macular Degeneration Center.

_____ _____
Patient's Signature (or Authorized Representative/Guardian) Date

INSURANCE INFORMATION

Please print and provide complete information.

There is no guarantee that your insurance company will pay for all services rendered. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. If we have not received payment within 60 days we will notify you and unpaid balances will become your responsibility, and we will expect payment in full at that time. It is the patient's responsibility to pay any deductible or any portion of the charges as specified by the plan at the time of visit.

We are happy to help with insurance questions relating to how a claim was filed; however, specific coverage issues can only be addressed by the insurance company's member services department (number is on the insurance card).

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about financial arrangements may be directed to the physician's office at any time. Please do not hesitate to contact us. We are here to help you!

PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO ENSURE THAT ANY REQUIRED REFERRALS FOR TREATMENT ARE OBTAINED BEFORE THE VISIT OR THE PATIENT MAY BE FINANCIALLY RESPONSIBLE DUE TO LACK OF THE REFERRAL AT TIME OF SERVICE.

Primary Insurance Company _____ ID # _____ Group # _____

If different from patient: Subscriber Name _____ DOB _____ SSN _____

Secondary Insurance Company _____ Group # _____ ID# _____

****If different from patient:*** Subscriber Name _____

Date of Birth _____ SS# _____ Relationship _____

Assignment of Benefits / Authorization to release information:

I hereby authorize Newport Retina & Macular Degeneration Center to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors and hospitals.

I hereby authorize Newport Retina & Macular Degeneration Center, the group hospital benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Newport Retina & Macular Degeneration Center for charges not covered by this authorization.

I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Date

PATIENT HISTORY QUESTIONNAIRE

MEDICAL CONDITIONS / SURGERIES: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke

☐ Asthma ☐ Arthritis ☐ Thyroid Disease ☐ Migraine ☐ Other:

EYE CONDITIONS / PREVIOUS EYE SURGERIES: ☐ Retinal Detachment ☐ Macular Degeneration

☐ Glaucoma ☐ Cataracts ☐ Iritis/Uveitis ☐ Other: _____

CURRENT MEDICATIONS: **CURRENT EYE DROPS:**

ALLERGIES:

FAMILY HISTORY: ☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma ☐ Other:

Social History: Do you drink alcohol? Yes / No Do you smoke? Yes / No Do you use street drugs? Yes / No

Name: _____ **Date:** _____

HIPAA PRIVACY

DISCLOSURE & CONSENT

TO THE USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Newport Retina & Macular Degeneration Center (hereinafter referred to as "Newport Retina") will maintain a record of the care and services you receive at our facility. This consent only covers your protected health information created while you are a patient of Newport Retina. Your protected health information pertains to your diagnosis and/or treatment at Newport Retina, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Newport Retina's use and/or disclosure of protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Newport Retina and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of Newport Retina's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye (to examine the retina). Please expect that your eyes will be dilated at every visit.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr Kawji and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____	_____
Patient's Signature (*or Authorized Representative/Guardian*)	Patient Date of Birth
_____	_____
Witness's Signature	Date

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays, deductible, and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, Visa or MasterCard. There is a $25.00 service charge on all returned checks. After receiving a returned check, Newport Retina will only accept cash, credit card, or money order.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment, deductible, or co-insurance obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.

3. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will receive a statement from our office within 30 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

8. **In the unlikely event your payment is returned to us unpaid**, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

9. **Patient balance that remains outstanding for more than 90 days** might be turned over to a collection agency. In this case, all collection fees will be the patient's responsibility.

10. **Missed appointments and cancelation policy.** If you are unable to keep a scheduled appointment, please kindly give us a 24-hour notice. We understand that circumstances occasionally arise that prevent you from keeping an appointment. Otherwise, you may be charged a $50 no-show fee.

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

_____ _____

Witness's Signature Date