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 _____)

Primary Care Doctor (if not referring doctor)_____ Phone_____

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 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. I understand that I am financially responsible for ALL charges for services rendered to me by Newport Retina.

_____ _____

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

INSURANCE 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 _____ ID # _____ Group # _____

Assignment of Benefits / Authorization to release information:

I hereby authorize Newport Retina to release information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies.

I hereby assign to Newport Retina, the group insurance benefits, including Medicare, herein specified and otherwise payable to me. I understand that I am financially responsible to Newport Retina 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: ☐ Diabetes ☐ High Blood Pressure ☐ Atrial Fibrillation ☐ Heart Attack ☐ Stroke ☐ Rheumatoid Arthritis ☐ Asthma ☐ Other:

- Surgeries (Non-Eye Related):

- Eye Conditions: ☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma ☐ Uveitis/Eye Inflammation ☐ Other:

- Previous Eye Surgeries (list date and surgeon name)**:**

- Current Prescription Medications:

- Current Prescription Eye Drops:

- Allergies to Medications:

- Family History: ☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma ☐ Other:

- Social History: ☐ Smoking ☐ Alcohol ☐ Street Drugs

- Why are you seeing the doctor today?

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 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 the opportunity to review our Notice of Privacy Practices (available on our website or in the office upon request) 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 reactions, 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.

NOTE: REVERSAL DILATION DROPS ARE AVAILABLE. PLEASE INQUIRE AT THE FRONT DESK.

_____ _____

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

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.** There is a $50.00 service charge on all returned checks. After receiving a returned check, Newport Retina will only accept cash, credit card, or money order.

2. **IMPORTANT: PLEASE READ IF YOU HAVE A PPO INSURANCE POLICY:** If you have any remaining deductible or co-insurance, we will collect those patient responsibility amounts upfront before you are seen by the doctor. Once your insurance processes the claim, this may result in a refund on your account (or an additional amount of patient responsibility). Any extra payment that was made by you will be refunded (or remain as a credit for future visits if you choose to do so). If you still have over $250 of remaining deductible/co-insurance, we will collect $250 before your first visit ($200 before follow up visits). Please understand that this is a strict policy which is necessary for efficient operations of this practice.

3. If your insurance requires a referral, it is your responsibility to verify that the referrals are in place prior to your visit.

4. **Our facility will file both primary and secondary insurance claims for medical services rendered.**
We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

5. **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.

6.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 directly. Payment of the patient's portion of the balance is due upon receipt of the statement.

7. **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.

8. **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.

9. I**n 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.

10. **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.

11. **Missed appointments and cancellation policy.** We understand that unexpected circumstances may occasionally prevent you from keeping a scheduled appointment. If you need to reschedule or cancel, please notify us at least 24 hours in advance. Failure to provide advance notice may result in a $100 no-show fee. Please note this fee is subject to change. Thank you for your cooperation and understanding.

_____	_____	_____
Patient's Signature	Date	Date of Birth