The RETINA CENTER®

Date:

Welcome to THE RETINA CENTER please answer the following:

Age: _____ Reason for seeing us: _____

Regular Medical Doctor: _____ Referring Doctor: _____

Preferred Pharmacy _____

HAVE YOU EVER BEEN DIAGNOSED WITH: (check those which apply) NONE ☐

☐Diabetes ☐Type I ☐ Type II For How Long?__years __
☐High Blood Pressure -For How Long? ____years __
☐Cancer of _____
☐Other_____

☐Kidney Disease
☐Thyroid Disease
☐**Heart Disease**
☐**Lung Disease**

OCULAR HISTORY check and indicate relation: NONE ☐

☐ Glaucoma ☐self ☐family
☐ Lazy Eye ☐self ☐family
☐ Blindness ☐self ☐ family
☐ Macular Degeneration ☐self ☐family
☐ Retinal Detachment ☐self ☐family
☐ Cataract ☐self ☐family
☐ Other__ _____ ☐self ☐family

Previous Eye Surgery, Indicate Eye and Year Performed: NONE

Cataract Removal	right _____	left _____
Retina Detachment	right _____	left _____
Laser Surgery	right _____	left _____
Glaucoma Surgery	right _____	left _____
Cornea Surgery	right _____	left _____
Other_____	right _____	left _____

List of drug allergies you may have: ☐ NONE

_____

INFO REVIEWED WITH PATIENT **RNM/MWH**

List all current medications including eye drops:

_____

_____

_____

SOCIAL HISTORY Have you ever or do you currently:

Do (did) you smoke?: ☐Yes ☐No _____pack(s) per for years Quit_____

Do (did) you drink alcohol? ☐Yes ☐No How much:___per day/week/year Quit_____

Review of Systems:

OCULAR (check)

☐ Temporary loss of vision ☐right ☐ left
☐ Flashing Lights ☐right ☐ left
☐ Red eye ☐right ☐ left
☐ Eye Pain ☐right ☐left
☐ Double vision ☐right ☐ left
☐ Black spots/cobwebs ☐right ☐ left
☐ Blurred vision ☐right ☐ left
☐ Droopy eyelid ☐right ☐left
☐ Line distortion ☐right ☐left

CURRENT BODY DISORDERS (describe)

General: ☐fever ☐sweats ☐weight loss
Skin Condition ☐Y ☐N _____
Ear/nose/throat ☐Y ☐N _____
Lung (breathing) ☐Y ☐N _____
Heart (i.e.chest pain) ☐Y ☐N _____
Intestine(gastric) ☐Y ☐N _____
Kidney ☐Y ☐N _____
Headaches ☐Y ☐N _____
Depression/Anxiety ☐Y ☐N
Pregnant ☐Y ☐N _____

NAME _____ **DATE** _____

THE RETINA CENTER, PA

Robert N. Mames, M.D./Michael W. Hines, M.D.

Today's Date: _____ Social Security Number: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Sex: M / F Marital Status: ☐S ☐M ☐W ☐D

Which Doctor Referred You? _____ If Under 18: _____
(Doctor's Name) (Parent's Name)

Email Address: _____

Whom May We Contact in Case of Emergency? _____ Phone: (___) _____

☐ Home Address ☐ School Address ☐ Visiting Address ☐ Winter Address.

Address: _____ Apt./Lot _____ City: _____

State: _____ Zip Code: _____ Home phone Number: (_____) _____

Cellular/Mobile Phone: (_____) _____ Other (_____) _____

IF THIS IS A TEMPORARY ADDRESS OR IF POST OFFICE BOX, PLEASE GIVE US YOUR PERMANENT PHYSICAL ADDRESS BELOW:

Address: _____ Apt./Lot _____ City: _____

State: _____ Zip Code: _____ Phone Number: (_____) _____

I authorize The Retina Center, PA to, dilate my eyes, treat me and release information to my physicians and the insurance carriers for billing purposes. Dilation may affect my ability to operate a motor vehicle and I have been informed that I should not drive. As a courtesy, The Retina Center, PA will attempt to file with my insurance company. I understand I am ultimately responsible for any unpaid balances (not the insurance company or any other third party), including attorneys fee and expenses associated with the collection of unpaid balances, and/or court costs and expenses if necessary. For any unpaid balances late payment interest at statutory rates may apply. I request that payment of authorized benefits from Medicare/Commercial Insurance be paid directly to The Retina Center, PA. If I am a member of a managed care program, and do not have adequate authorization to be treated, then I will assume all financial responsibilities, including costs to collect any debts. This constitutes a lifetime authorization of benefits. I have also read and understood The Retina Center, PA Privacy Statement.

If you are unable to keep your appointment, please notify our office at least 24 hours in advance to avoid a cancellation fee of $50.00 for office visits or $75.00 for procedures. All appointments must be confirmed at least 24 hours prior to the scheduled appointment time. Failure to provide timely notice or attend your scheduled appointment may result in the applicable fee being charged to your account.

Signature of Patient or Responsible Party: _____

The RETINA CENTER®

DOCTOR-PATIENT ARBITRATION AGREEMENT
PLEASE READ CAREFULLY
Your signature on this form is required prior to seeing Dr. Mames or Dr. Hines

This agreement is made between Retina Center, P.A. doing business as The Retina Center, Dr. Robert Mames, Dr. Michael Hines, other medical physicians, physician assistants, their agents, employees, or any of the foregoing, referred to hereafter as "Doctor" and referred to hereafter as the "Patient." It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any persons deriving claims through or on behalf of the patient.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for us under Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction in and for Alachua/Marion Counties, Florida. Requests for arbitration by either party must be made within the time frames set forth in section 95.11 of the Florida Statutes dealing with medical malpractice. All arbitration awards for all claims against any parties of the Retina Center, P.A. doing business as The Retina Center, Dr. Robert Mames and Dr. Michael Hines, shall be limited to $100,000.00 total. This amount shall include all fees, awards, damage and costs.

This agreement shall remain in effect for all treatment and/or surgery provided the patient presently and at any future date. If any portion of this agreement is found to be unconstitutional, illegal or overturned, the remaining parts of the agreement are still in effect.

Your signature on this form is required prior to seeing Dr. Mames or Dr. Hines.

In witness whereof(we) have set our hands this date Date: _____

Patient Signature: _____

Doctor: Dr. Robert Mames/Dr. Michael Hines Patient:

By: _____ _____

Authorized Agent Signature PATIENT CODE

North Florida Medical Arts Building ■ 6400 Newberry Road, Suite 301 ■ Gainesville, Florida 32605 ■ (352) 333-5050
3035 SW 27th Ave ■ Ocala, Florida 34471 ■ (352) 873-7300

The RETINA CENTER®

The Retina Center, P.A. Privacy Statement

The Retina Center, P.A. has created this statement in order to demonstrate our firm commitment to privacy.

Each time you visit The Retina Center, P.A. physicians, a record of your visit is made. This record contains symptoms, test results, diagnoses, and treatment plans. This information is referred to as your Protected Health Information or PHI and serves as a tool for communication among the health care professionals who contribute to your care and the staff of The Retina Center, P.A. for effective planning and treatment of each patient. Your PHI is also used for legal documentation describing the care you received for billing purposes. In some cases, your PHI is used for educating health care professionals and patients for a better understanding of diagnoses and treatment plans.

You have the right to the information in your PHI, although they are the property of the health care professional that compiled it. You may obtain a paper copy, inspect and amend information in you PHI up request under supervision of physician and/or staff.
Please refer to http://www.hipaaps.com/cgi-bin/viewlaw.cgi

It is the responsibility of The Retina Center, P.A. to maintain the privacy of your PHI and to provide you with a notice of our legal duties pertaining to your PHI by abiding by the terms of this notice. It is the right of The Retina Center, P.A. to make changes and provisions to this privacy policy as new information is provided to us. We will advise patients of these changes accordingly.

Samples of, but not all inclusive, Treatment, Payment and Health Operations

We will use your PHI for treatment: For example: Information obtained by a technician, nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you., Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment/collections: For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
We will use your health information for regular health operations: For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Permitted or Required Uses and Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the operating room, surgical centers, emergency departments, radiology, certain laboratory tests, and a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard our information.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, you location, and general condition.
Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care such as appointment changes, schedule changes, diagnostic scheduling, etc.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

The above are only examples, as not every situation for disclosure of PHI can be foreseen.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the director of health information management at (352) 333-5050, (352) 873-7300 or visit the official site of HIPAA at http://www.hippa.com.

If you believe your privacy rights have been violated, you can file a complaint with the director of health information management or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.