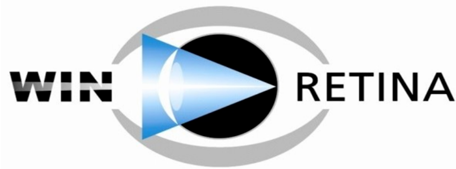


MEDICAL HISTORY QUESTIONNAIRE

Date: __________

Patient Name:_______________ **Date of Birth: ___________**

Do you presently have any problems in the following areas? If "YES", give an explanation:

EYES	Yes	No	EXPLANATION OF PROBLEM
Loss of vision	( )	( )	**Right ( ) Left ( )**
Blurred vision	( )	( )	**Right ( ) Left ( )**
Double vision	( )	( )	**Right ( ) Left ( )**
Shadow	( )	( )	**Right ( ) Left ( )**
Floaters	( )	( )	**Right ( ) Left ( )**
Flashes of Light	( )	( )	**Right ( ) Left ( )**
Injuries to eyes	( )	( )	**Right ( ) Left ( )**
Distorted vision	( )	( )	**Right ( ) Left ( )**
Loss of peripheral vision	( )	( )	**Right ( ) Left ( )**
Glaucoma – If "YES", how long?	( )	( )	**Right ( ) Left ( )**
Retinal Detachment If "YES" when?	( )	( )	**Right ( ) Left ( )**
Redness	( )	( )	**Right ( ) Left ( )**
Sandy or gritty feeling	( )	( )	**Right ( ) Left ( )**
Itching	( )	( )	**Right ( ) Left ( )**
Dryness	( )	( )	**Right ( ) Left ( )**
PATIENT HISTORY	**Yes**	**No**	**EXPLANATION OF PROBLEM**
Cardiovascular (heart / blood vessels) including any history of heart attacks	( )	( )	
Hypertension & How long even if controlled by medication)	( )	( )	
Diabetes & How long	( )	( )	
Respiratory (lungs / breathing / T.B / asthma / emphysema	( )	( )	
Genitourinary (genitals / kidney / bladder)	( )	( )	
Musculoskeletal	( )	( )	
Muscle pain	( )	( )	
Joint pain (arthritis)	( )	( )	
Circulatory Problem	( )	( )	
Cancer	( )	( )	
Thyroid Disease	( )	( )	
Other Eye or Systemic Disease	( )	( )	

List any medications you take including blood thinner (aspirin, coumadin..etc) or any over the counter meds including eye drops:

____

____

____

____

List all surgeries you have had in the past, including eye surgery:

____

____

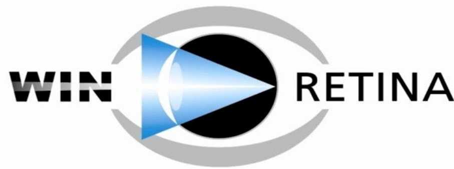
____

Do you have allergies to any medications? ( ) YES ( ) NO

If YES, list medications and side affects:

____

____



REGISTRATION FORM
(Please complete form)

Last Name ___________________________First Name____________________MI______ DOB: ___/___/_____

Address: ______________________________________City/State/Zip: _________________________________

Home Phone: (   )_____- _________   Cell : (   )_____ - _________   Work Phone: (   )_____ -______

SSN: ______-______-______Gender:_____ Marital Status: ___E-Mail address: __________________________

Name of Emergency Contact: ________________Phone :(   )______-_______ Relation: ________

Primary Care Physician / Phone: ______________________________________/ (   ) _______- _______

Referring Physician / Phone: ____/ (   ) _______ - ________

OFFICE USE ONLY: Referring Dr NPI: _________________________Fax:(   )________-__________

INSURANCE INFORMATION:

Primary Insurance:

Insurance Name: ________________________________ Policy/ Member ID:____________________________

HMO: Yes ____ NO____ (If yes, Group Name IPA ____)

Secondary Insurance:

Insurance Name: ________________________________ Policy/ Member ID:____________________________

POLICY HOLDER / FINANCIALLY RESPONSIBLE PARTY (if different from above):

Policy Holder Name: _________________________Address:

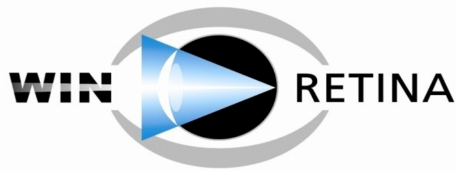
Relationship: ______________________SNN: ________-______-______ DOB: _______/______/

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our Patient Relations Dept. PRIOR TO SURGERIES.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARTATION:
I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:
I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.

DATE: ________/_________/_________ SIGNATURE: ___________________________________



PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Patient Name: ____ **Date of Birth:**________________________

Thank you for choosing Peter Ho Win, MD Inc (Win Retina). We are committed to the success of your treatment. We hope you understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by our doctors.

It is our policy that the patient, rather than the insurance company, is responsible for the complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any co-pay amount due at the time of services are rendered. For patients with dual insurance, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are **NOT CONTRACTED** with or **DO NOT have insurance** will be required to pay as an "Out of Pocket Patient" for the initial consultation in full. For any follow up visits, patients will need to pay accordingly.

If you are insured with a plan, which we are contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your co-pay amount at the time of each visit.

There is a fee of $15.00 for all disability, FMLA and any other forms/paperwork that you need to have filled out by the physicians.

There is a fee for any reports or medical records requested by attorneys, insurance companies, disability companies, etc… This charge will be determined by the information requested.

For prescription refills, please have your pharmacy fax a request to **626-447-7009**. Please allow 48 to 72 hours.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from Win Retina or possible collection agency.

Our accepted methods of payment are VISA, MasterCard, cash and checks. There will be a $45 fee for any bounced checks, thereafter, patients are required to pay with cash. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

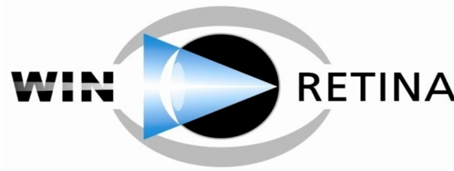
It is the patient's responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treated by doctors outside of the designated network or if the proper authorizations have not been obtained.

Again, thank you for trusting us with your ophthalmologic care. If you have any questions regarding financial responsibility or payment options, please contact our office.

"I have read, understood, and agree to the provisions of this policy"

____ _____________________________________

Signature (Patient/Guardian) Date



HIPAA Patient Consent Form

(Please complete form)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- WIN RETINA has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- WIN RETINA reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but WIN RETINA does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- WIN RETINA may condition treatment upon the execution of this Consent.

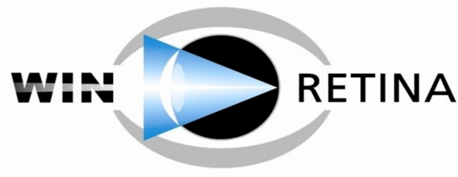
By signing this form, you give your consent to use and disclosure of protected health information about you for our treatment, payment and healthcare operations purposes. Federal law requires that we obtain written consent of this kind.

The Consent is signed by:

Patient Name or Representative: ____

Signature: _____________________________________ Date: _____________________________

Relation to Patient (if not patient signing) _________________________________



Insurance Acknowledgement

I understand that it is my responsibility to notify WIN RETINA of any changes to my insurance. Failure to do so may reflect a balance on my account with WIN RETINA.

Patient Name:___________________________________ Date Of Birth:_________________________

Patient Signature:________________________________ Date:__________________________________

If you have any further questions,
please feel free to ask the receptionist or contact our billing department at (626) 447-7008
Thank You