Mid Atlantic Retina Specialists

Diseases and Surgery of the Retina, Macula and Vitreous

Date: ______________________________

Dear ____________________________________,

Mid Atlantic Retina Specialists would like to welcome you to our practice. You have been referred to us because you have been potentially diagnosed with a disorder associated with your retina, macula and/or vitreous.

Mid Atlantic Retina Specialists provide the highest quality of care in our modern offices. We have the ability to not only perform specialized eye examinations, but also many procedures including laser surgery and other treatments in the comfort of our clinic setting. Our physicians are on staff with the Robinwood Surgery Center, Meritus Medical Center, and Frederick Memorial Hospital, performing surgery there when indicated.

Your upcoming appointment with us is on ____, @ __________________am / pm. You will be seen by Dr.________________________ in our ________________________________ office. Enclosed you will find the paperwork we need you to complete and return with you on your first appointment. Should you have any questions regarding the paperwork, you can call our main office at (301) 671-2400, and one of our staff members will be more than happy to help you through the process.

Along with the enclosed paperwork, please make sure to bring your medication list, photo ID, your insurance card(s), and if your insurance requires it, a referral. Also, any co-pays and/or co-insurance should be paid at the time of service.

When you come in for your initial visit with us you can expect to be here anywhere from one and a half to three hours depending on the need for diagnostic test(s). You should also expect that your eyes will be dilated, so if you have trouble driving while dilated, please bring along a driver. We look forward to assisting you in the care of your eyes.

Sincerely,

Mid Atlantic Retina Specialists

☐ 246 Eastern Blvd. Suite 102, Hagerstown, MD 21740
Tel (301) 671-2400 Fax (301) 671-2403
☐ 174 Thomas Johnson Drive, Frederick, MD 21702
Tel (301) 228-2946 Fax (301) 228-2945
☐ 961 South Main Street, Chambersburg, PA 17201
Tel (717) 552-2437 Fax (717) 552-2507

Patient Registration Form

Date: ______/______/______

First Name	Middle Name	Last Name	Sex
Home Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Date of Birth / /	Age	Social Security Number	Marital Status o S o M o D o W	E-mail Address
Patient Employer / Occupation (indicate if student)	Financially Responsible Person o Patient o Spouse o Parent o Other	Name (if different from patient)
Do You have a POA (power of attorney) o Yes o No Name of POA:		
Is patient residing in Skilled Nursing Facility? o Yes o No	Address	Facility Phone Number
Emergency Contact	Relationship	Phone Number
Referring Physician		Phone Number

PRIMARY INSURANCE:		
Carrier	Address	Phone Number
ID #	Group #	Effective Date / /
Policyholder	Policyholder SSN	Date of Birth / /

SECONDARY INSURANCE:		
Carrier	Address	Phone Number
ID #	Group #	Effective Date / /
Policyholder	Policyholder SSN	Date of Birth / /

TERTIARY INSURANCE:		
Carrier	Address	Phone Number
ID #	Group #	Effective Date / /
Policyholder	Policyholder SSN	Date of Birth / /

Chart #: ___________________________

Financial Policy Statement

Welcome to Mid Atlantic Retina Specialists. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. We ask that you carefully read and sign the following policy. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/ or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibility. This includes, obtaining any referrals and/or authorizations, which your insurance company requires before care is provided.
All co-pays, co-insurance and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered.

If my account becomes assigned to collection agency, I agree to pay 30% collection fees, court costs and attorney fees. I understand that Mid Atlantic Retina Specialists reserves the right at its sole discretion, to waive said requirements on a case-by-case basis.

In consideration of the services performed by Mid Atlantic Retina Specialists, you agree to abide by the terms of this
Financial Statement.

Signature: ____ Date: ____/_____/_____

Patient's Authorization

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signature: ____ Date: ____/_____/_____

Mid Atlantic Retina Specialists

Robert E. Parnes, M.D.
Adam T. Gerstenblith, M.D.

Communication Agreement

I, ______________________________ give Mid-Atlantic Retina Specialists permission to discuss the following:

☐ Diagnosis, prognosis, and/or treatment information
☐ Test Results
☐ Scheduling information
☐ Billing information
☐ Other (please specify):____________________

With the following people:

____ Relationship: ___________

____ Relationship: ___________

____ Relationship: ___________

I also authorize Mid-Atlantic Retina Specialists to:

☐ Leave messages on my home answering machine/voice mail
☐ Leave messages on my work answering machine/voice mail
☐ Leave messages with my family members or others answering the phone in my home .

Signature: ________________________________ Date:________________

Note: This form must be filled out completely in order for Mid-Atlantic Retina Specialists to ensure the privacy and confidentiality of our patients' protected health information. The instructions on this form will be considered current until a new Communication Authorization supersedes them. It is the patients' responsibility to file a new form with Mid-Atlantic Retina Specialists if there are changes in your household situation. Mid-Atlantic Retina Specialists is not responsible for undesired communications resulting from the failure of a patient to file a new Communication Authorization form.

MID ATLANTIC RETINA SPECIALISTS

Robert E. Parnes, M.D.
Adam T. Gerstenblith, M.D.

Acknowledgement Notice of Privacy Practices and Consent

The Patient hereby consents to the use or disclosure of his/her individually protected health information by **MID ATLANTIC RETINA SPECIALISTS** in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, we will post a summary of the current notice in our office with the effective date. You are entitled to a paper copy upon request.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent

As required by law **MID ATLANTIC RETINA SPECIALISTS** has provided you with Notice of Privacy Practices. This notice describes information about privacy practices followed by our health care providers, employees, staff and other office personnel. It also describes your rights and obligations in which information and records that we may have about your health, health status and the healthcare and services you receive at this office may be used or disclosed.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO THE ABOVE STATED TERMS.

______________________________ Patient Signature

______________________________ Please print name

______________________________ Person signing on behalf of Patient

______________________________ Please print name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

____

____

Witness signature: ______________________ Date______________ Time____________

Medical History Questionnaire Date: ____________

First Name:________________ Last Name:__________________ MI:_____

Primary Pharmacy:______________________ Phone:____________
Address:______________________

Primary Care Physician:__________________ Phone:____________
Address:______________________

1. What problems are you currently having with your eyes?

- □ Floaters/spots
- □ Flashing Lights
- □ Blurred Vision
- □ Distortion/waviness
- □ Loss of side vision
- □ Sensitivity to light/glare
- □ Pain
- □ Trouble with colors
- □ Other: __________________

Which Eye?
- □ Right
- □ Left

2. Have you had any eye problems in the past? (e.g. cataract, glaucoma, retina problems, eye surgery, etc.)

□ Yes □ No If yes, please explain:_________________________________

3. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, heart disease, asthma etc.)

□ Yes □ No If yes, please explain:_________________________________
____

If diabetic, type 1 or 2 and for how long?___________________________

(PSFH/ROS)

4. Have you had any of the following problems?

	Yes	No	If yes, please explain:
(Constitutional) Chronic fever, unexpected weight loss/gain, fatigue	□	□	
(HENT) e.g. hearing loss, sinus problem, sore throat	□	□	
(Cardiovascular) e.g. chest pain, irregular heartbeat	□	□	
(Respiratory) e.g. shortness of breath, wheezing, asthma, bronchitis	□	□	
(Gastrointestinal problems) e.g. heartburn, abdominal, pain, diarrhea	□	□	
(Urinary) e.g. pain or discomfort, bladder infections)	□	□	
(Integumentary) e.g. rashes, eczema, dermatitis	□	□	
(Musculoskeletal) e.g. muscle aches, arthritis, swollen joints	□	□	
(Neurologic) e.g. numbness, weakness, paralysis, headaches	□	□	
(Psychiatric) e.g. depression, anxiety	□	□	

Last Name:__________ **D.O.B.**__________ **Chart #** __________

5. **Please List all of your eye drops.**

Name	Which Eye	How Often

6. **Have you had any surgeries?** ☐ Yes ☐ No

If yes please list:

Surgery Type	When

7. **Please list any current medications:**

Medication	Dosage	How often

8. Are you allergic to any medications: ☐ Yes ☐ No

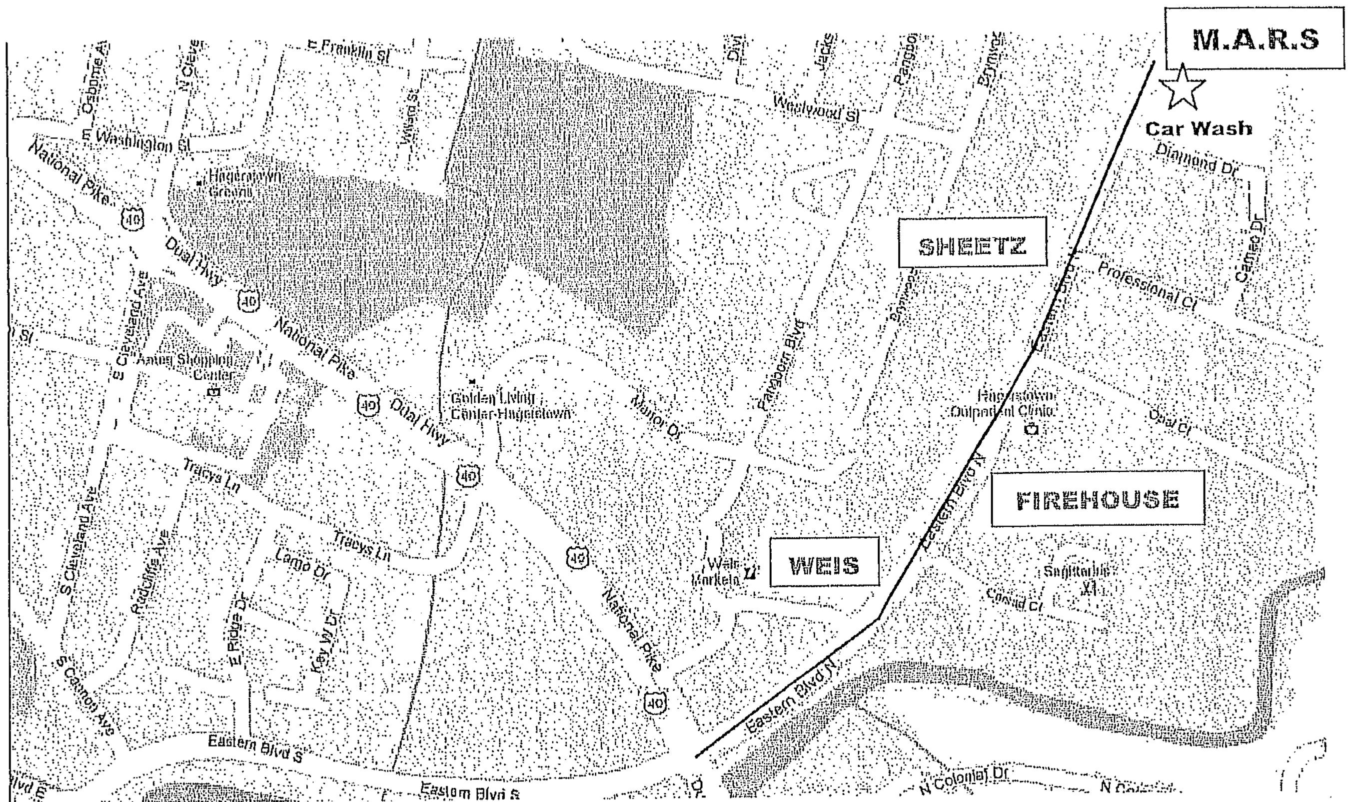
If yes please list them:______________________________

____

9. **Family History**

	Yes	No	Relationship (M=mother F=father S=sibling GP=grandparent)
Macular Degeneration			
Diabetic Retinopathy			
Retinal Detachment			
Glaucoma			
Heart Disease			
High Blood Pressure			
Diabetes			
Stroke			
Cancer			
Other:			

DIRECTIONS TO NEW HAGERSTOWN OFFICE



FROM THE NORTH

- 81 South towards Hagerstown, MD
- Exit 6A in MD (Route 40 East) drive approx. 3.4 miles
- Turn left on Eastern Blvd, go 0.3 miles office is on Right

FROM THE SOUTH

- Take Route 81 North toward Hagerstown, MD
- Take 70 East towards Frederick, MD
- Take Exit 32B (Route 40 West)
- Drive 2.7 miles to Eastern Blvd
- Turn right at light
- Drive 0.3 miles to our office on Right

FROM THE WEST

- Take 70 East towards Frederick, MD
- Take Exit 32B (Route 40 West)
- *Follow directions from above ("from the south")*

FROM THE EAST

- Take 70 West toward Hagerstown, MD
- Take Exit 32B (Route 40 West)
- *Follow directions from above ("from the south")*

246 Eastern Blvd. (North) Suite 102, Hagerstown, MD 21740

DIRECTIONS TO FREDERICK OFFICE

174 Thomas Johnson Drive Suite 204 Frederick, MD 21702

FROM THE NORTH

- 15 South towards Frederick, MD.
- Turn Right onto Hayward Road.
- Turn Left onto Thomas Johnson Drive.
- Proceed until you see Building #174 on the Left.
- We are in Suite 204 (on the right end of the front of the building).

FROM THE SOUTH

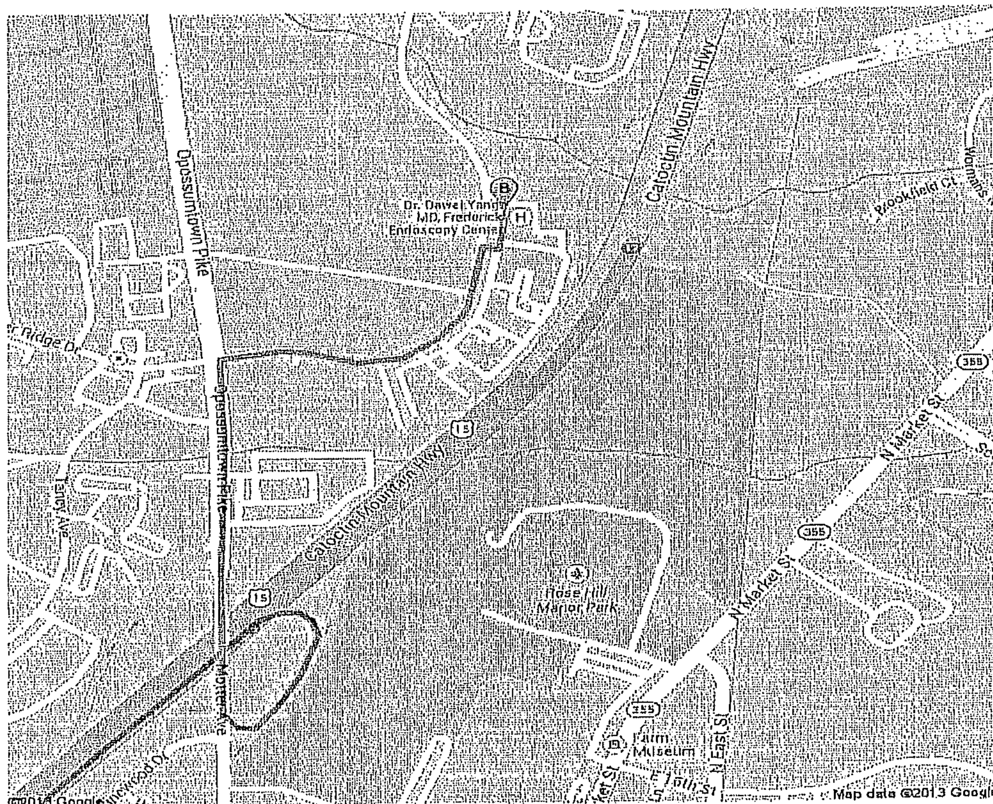
- 270 North towards Frederick, MD.
- Take 15 North.
- *Take the Motter Ave./Opossumtown Pike exit.*
- *Turn Right onto Opossumtown Pike.*
- *At the 3rd light, turn Right onto Thomas Johnson Drive.*
- *Proceed until you see Building #174 on the Right.*
- *We are in Suite 204 (on the right end of the front of the building).*

FROM THE WEST

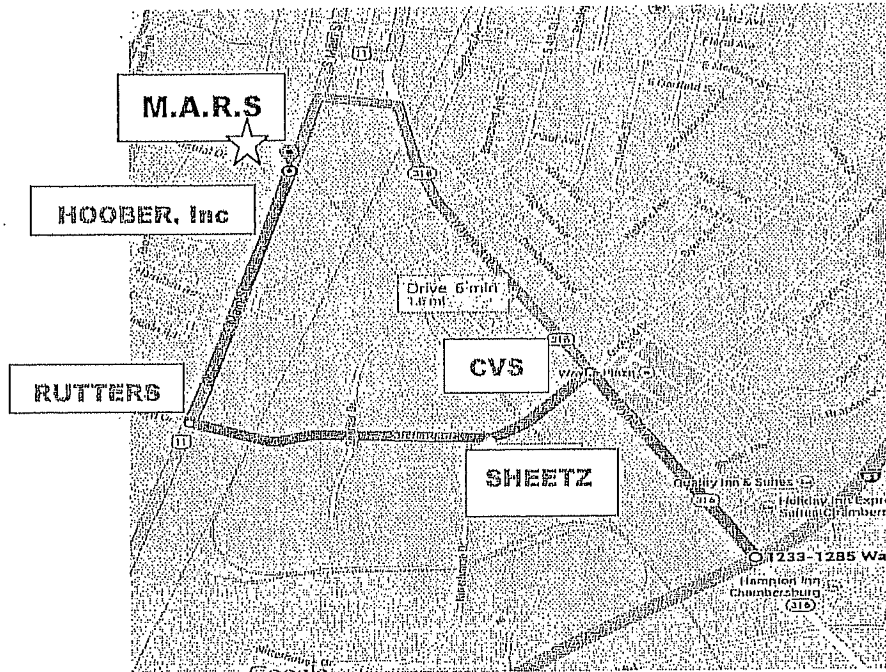
- 70 East towards Frederick, MD.
- 15 North.
- Follow directions from above *("from the south")*.

FROM THE EAST

- 70 West towards Frederick, MD.
- Take 15 North.
- Follow directions from above *("from the south")*.



DIRECTIONS TO NEW CHAMBERSBURG OFFICE



961 South Main Street, Chambersburg, PA 17201

From The South

- Take Route 81 North toward Harrisburg, PA
- Take Exit 14 PA-316/Wayne Ave.
- Turn Right off of Exit onto Wayne Ave.
- Turn Left onto Orchard Drive
- Turn Right onto S. Main Street
- Destination will be on your left in about 0.6 miles

From The East

- Take US 30/ Lincoln Hwy 6.2 miles
- At the traffic circle take the second left S. Main Street
- In 1 mile your destination will be on the right

From The West

- Head Southeast On Lincoln Hwy E toward N. 3rd street
- Turn right onto U.S. 30 E for 19.6 miles
- Turn Right onto South Main Street in 0.9 miles destination will be on your right

From the North

- Head Southeast on US-1 S / E King St toward N Earl Street for 9.8 miles
- Turn Right onto Edgar Ave
- Take the 2nd Right onto College Ave
- Slight Left onto Philadelphia Ave
- Continue onto S. Main Street. At the traffic circle continue straight onto S Main Street, destination is on the right