Mid Atlantic Retina Specialists

Diseases and Surgery of the Retina, Macula and Vitreous

Dear: _____, Date: _____

Mid Atlantic Retina Specialists would like to welcome you to our practice! We provide the highest quality of care in our modern offices. We have the ability to perform specialized eye examinations, many procedures (including laser surgery), and other treatments in the comfort of our clinic setting. Also, our physicians are on staff with Meritus Medical Center, 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 paperwork 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, insurance card(s), and a referral if your insurance requires it. Also, your co-pay 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. North Suite 102, Hagerstown, MD 21740
Tel (301) 671-2400 Fax (301) 671-2403

☐174 Thomas Johnson Drive, Suite 204, 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

☐311 Hospital Drive, Everett, PA 15537
Tel (814) 623-1969 Fax (814)623-5590

Patient Registration Form

Date: _____/_____/_____

First Name	Middle Name	Last Name	Sex o Male o Female
Home Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Date of Birth / /	Age	Social Security Number	Marital Status oS oM oD oW	Patient Employer/ Occupation (indicate if student)
Race: o Native American o White o Asian o African American o Other o Decline	Ethnicity: Hispanic/Latino o Yes o No o Decline	Preferred Language: o English o Spanish o Other_____
Do You have a POA (power of attorney) oYes o No Please Provide POA Documentation Name of POA:	POA Phone Number	Financially Responsible Person o Patient o Spouse o Parent o Other
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 Care 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 / /

Financial Policy Statement

Name:_____ DOB: _____

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 carrier. 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 of payment(s) from them. 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 your sole responsibility. You are expected to understand your insurance benefits and coverage, and to obtain any referrals and/or authorizations, 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 participate with your insurance company, you are responsible for 100% of the payments at the time services are rendered.

If your account becomes assigned to a collection agency, you agree to pay the 36% collection fees, court costs, and attorney fees if applicable. 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 policy.

You authorize the release of any necessary information, including medical information for this or any related claim to your insurance carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.

Patient/Guarantor Signature: _____ Date: _____

MID ATLANTIC RETINA SPECIALISTS

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" (Notice) 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.

The facility reserves for itself the right to change the terms of its Notice at any time. If the facility does change the terms of its Notice, it will post a summary of the current Notice in the office with the effective date. You are entitled to a paper copy upon request.

Patients retain 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 does agree to Patient's requested restriction(s), such restrictions are then binding on the facility.

At all times, the 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 its 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 DOCUMENT VERIFYING RECEIPT OF NOTICE OF PRIVACY PRACTICES. I 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: _____

Mid Atlantic Retina Specialists

Communication Agreement

I, _____ give the physicians/staff of Mid Atlantic Retina Specialists the following permission:

To discuss my healthcare which includes the following:

- ☐ Diagnosis, Prognosis, and /or treatment information
- ☐ Test Results
- ☐ Scheduling information
- ☐ Billing information
- ☐ Other (please specify): _____

With the following people:

_____Relationship: _____Ph Number_____

_____Relationship: _____Ph Number_____

_____Relationship: _____Ph Number_____

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Also, I authorize the physicians/staff of Mid Atlantic Retina Specialists:

Yes No Leave messages on my home answering machine/voice mail

Yes No Leave messages with my family members or others answering the phone in my home

Yes No Leave messages on my work answering machine/voicemail

_____OK to call but DO NOT LEAVE **ANY** MESSAGES

_____DO NOT CALL ANY OF MY PHONE NUMBERS
(Post-Op and/or Billing Related Calls Are Excluded From This Request)

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 our office if there are changes in your household situation. Mid Atlantic Retina Specialists are not responsible for undesired communications resulting from the failure of a patient to file a new Communication Authorization form.

PATIENT MEDICAL HISTORY

Name:_____ **DOB:**_____ **Date:**_____

Primary Care Physician: _____ Phone: _____

Address: _____

Primary Pharmacy: _____ Phone: _____

Address: _____

REASON FOR VISIT

☐ Blurred Vision	☐ Floaters	☐ Pressure in Eyes	**Which Eye?**
☐ Distortion of Vision	☐ Flashes	☐ Shadow/Curtain	☐ Right
☐ Decreased Vision	☐ Cobwebs	☐ Light Sensitivity	☐ Left

☐ Other_____

MEDICAL HISTORY (Past and Current medical conditions)

☐ Arthritis ☐ Blood Clots ☐ Cancer ☐ Depression/Anxiety ☐ Diabetes ☐ Heart Disease

☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Stroke ☐ Thyroid Disease

☐ Aids or Infectious Disease ☐ Bleeding Disorder, Anemia ☐ Lung Disease ☐ COPD

☐ Other: _____

If Diabetic: Last A1C value: _____ Date of last A1C:_____ Last Blood Sugar Reading: _____

Have you had one of the following in the CURRENT year?

☐ Flu Vaccine ☐ Pneumonia Vaccine

ALL SURGICAL HISTORY

SURGERY TYPE	DATE

CURRENT MEDICATIONS

If you have a list with you, please give it to the receptionist when you check in.

EYE DROPS

Name (strength/dosage if known)	Frequency	Which Eye	Reason for Using

ALL OTHER MEDICATIONS

Medication Name	Dose	Frequency	Start Date	For Diagnosis Of

ALLERGIES

☐ No Known Allergies

If yes, please list any allergies here:

_____

_____

SOCIAL HISTORY

Smoking: ☐ Never ☐ Current, if so, how many packs/day _____ ☐ Former, stop date _____

Alcohol: ☐ None ☐ Occasional/Social ☐ Daily

If over 65 years old, have you fallen in the last 6 months? ☐ Yes ☐ No

FAMILY HISTORY

This can include mom, dad, sister, brother, aunt, uncle, grandmother, grandfather, and/or your biological son/daughter.

DIAGNOSIS	Y	N	Who?
Blindness			
Cancer			
Cataracts			
Diabetes			
Glaucoma			
Heart Disease			
Hypertension			
Kidney Disease			

DIAGNOSIS	Y	N	WHO?
Macular Degeneration			
Retinal Detachment			
Stroke			
Thyroid Disease			
Uveitis			
Other:			
☐ **UNKNOWN / ADOPTED**			

REVIEW OF SYSTEMS:

Do you have any problems in the following areas? Please check yes or no.

CONSTITUTIONAL	**Y**	**N**
Fever		
Weight Loss		
Fatigue		
Loss of Appetite		
Other:		
HENT		
Hearing Loss		
Sore Throat		
Runny Nose		
Other:		
ENDOCRINE		
Diabetes		
Excessive Thirst		
Freq. Urination		
Cold Intolerance		
Heat Intolerance		
Other:		
GENITOURINARY		
Dialysis		
Painful Urination		
Blood in Urine		
Other:		
MUSCULOSKELETAL	**Y**	**N**
Arthritis		
Muscle Aches		
Joint Pain		
Other:		

CARDIOVASCULAR	**Y**	**N**
Heart Attack		
Heart Murmur		
Irregular Heartbeat		
Chest Pain		
Swelling of the Feet		
Other:		
RESPIRATORY	**Y**	**N**
Emphysema		
Wheezing		
Coughing		
Shortness of Breath		
Other:		
GASTROINTESTINAL	**Y**	**N**
Stomach Ulcers		
Constipation		
Abdominal Pain		
Nausea		
Diarrhea		
Other:		
ALLERGY/ IMMUNOLOGY	**Y**	**N**
Sjogren's Syndrome		
HIV		
Lupus		
Other:		

Integumentary	**Y**	**N**
Skin Cancer		
Rash		
Change in Mole		
Other:		
NEUROLOGIC	**Y**	**N**
Headaches		
Seizures		
Stroke		
TIA		
Weakness		
Paralysis Of Extremities		
Scalp Tenderness		
Dizziness		
Tremor		
Other:		
HEMATOLOGY/ONCOLOGY	**Y**	**N**
Anemia		
Easy Bruising		
Prolonged Bleeding		
Other:		
PSYCHIATRIC	**Y**	**N**
Depression		
Bipolar Disorder		
Schizophrenia		
Other:		

DIRECTIONS TO 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.
- Exit 18 to Monocacy Blvd/Christophers Crossing
- Turn Right onto Christophers Crossing
- 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

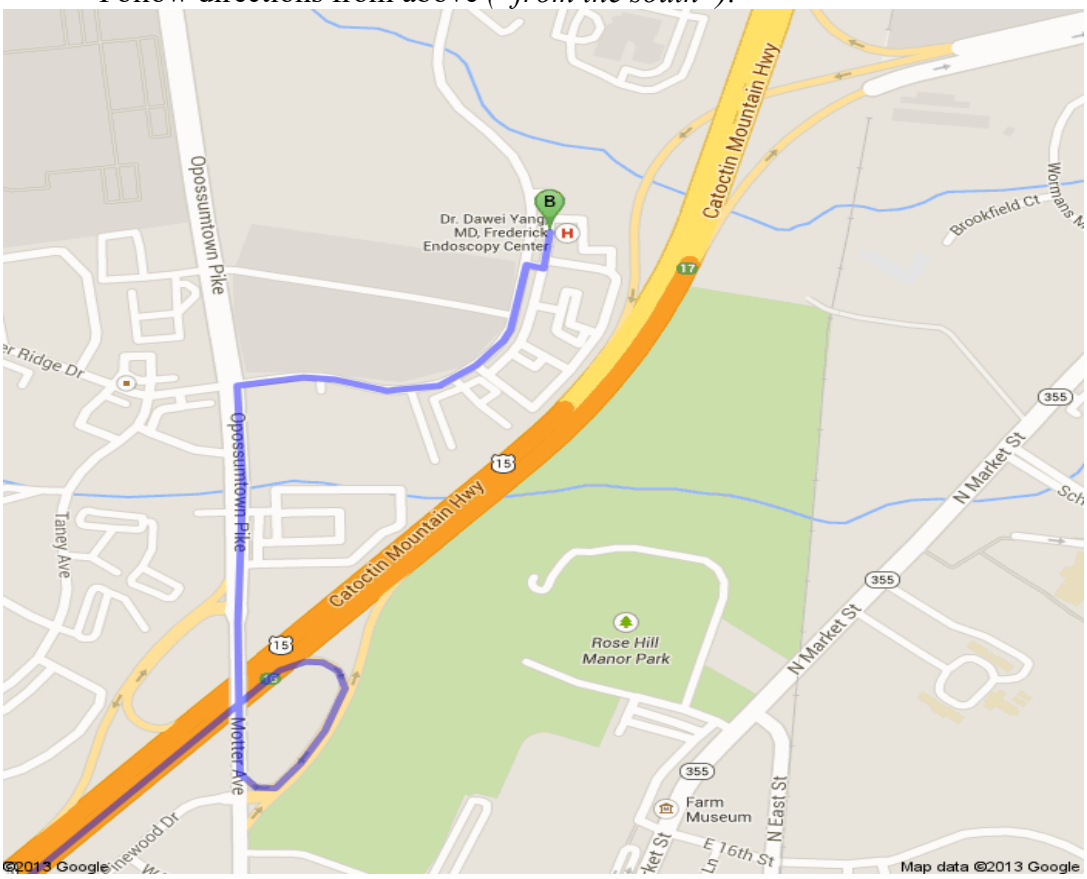
- 270 North towards Frederick, MD.
- Take 15 North.
- Take the Motter Ave./Opossumtown Pike exit.
- Turn Right onto Opossumtown Pike.
- At the 3rd light, turn Right onto Thomas Johnson Drive.
- Proceed until you see Building #174 on the Right.
- We are in Suite 204 (on the right end of the front of the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