RETINA NORTHWEST, P.C.

PATIENT REGISTRATION FORM

_____
APPOINTMENT DATE

PATIENT INFORMATION:

Name _____ M / F
Last First M.I. Sex

Address _____
Street Address City State Zip

Phone #: Home (_____) - Work (_____) Cell (____) -
Area Code Area Code Area Code

Birthdate _____/_____/_____ Age _____ Social Security # _____

E-mail Address: _____

Would you like to enroll in our Patient Portal? ___ Yes ___ No ___ Already enrolled

Emergency Contact Name: _____ Phone number: _____

Race:
____ American Indian or Native American
____ Asian
____ Black or African American
____ Native Hawaiian or Pacific Islander
____ White
____ Declined to Answer / Not reported

Ethnicity:
____Hispanic or Latino
____ Not Hispanic or Latino
____ Declined to Answer / Not reported

Preferred Language: _____

Marital Status (circle one): Single Married Widowed

Work Status:
_____ Working: ____Full Time ____Part Time
_____ Not Employed / Retired
_____ Student: ____ Full Time ____ Part Time

If working, please provide the following:
Occupation _____
Employer _____
Work Phone # (____) -

PRIMARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth _____/_____/_____ Subscriber's Sex M / F

Relationship to Patient _____ Subscriber's Employer _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name _____

Subscriber Name _____ Policy/ID# _____

Subscriber's Date of Birth _____/_____/_____ Subscriber's Sex M / F

Relationship to Patient _____ Subscriber's Employer _____

Which Doctor Referred You to Retina Northwest? M.D. O.D. D.O.
_____
First Name Last Name

_____
Address City State Zip

Phone# (_____)_____-_____
Area Code

Who is Your Primary Care Physician? M.D. D.O.
_____
First Name Last Name

_____
Address City State Zip

Phone# (_____)_____-_____
Area Code

Retina Northwest, P.C.

www.retinanorthwest.com

RETINA & VITREOUS DISEASES

Physicians and Surgeons

Today's Date:_____

Please help us with your evaluation by providing detailed information. Thank You.

Your name:

Date of birth: Gender: ☐ Female ☐Male

Your family doctor (primary care provider):	Date of last exam:
Your general eye doctor:	Date of last exam:

Pharmacy name:	Phone number:	
Address:	City:	State:

Do you wear a vision correction? ☐ No ☐Glasses ☐Contact lenses
How many years have you worn: Glasses?_____ Contact lenses? _____
Type of glasses:_____ (Bifocal, reading, trifocal, single vision, progressive)
Type of contacts:_____ (Soft, rigid gas permeable)

What changes in your vision led you to see an eye doctor recently?

What do you believe might be the problem?

Do you have any of these symptoms? ☐No (skip to next section)

Description	No	Right Eye	Left Eye	Notes: Severity? Duration?
No vision change				
Distortion (bent out of shape				
Blurring				
Dimness				
Blind spot or area				
Flashes or flickering				
Floaters				
Eyestrain				
Dry or burning eyes				
Severe light sensitivity				
Headache				

Please list any eye drops, medicines, and supplements that you take ***for your eyes:***					
Right Eye			Left eye		
Name	How often	For:	Name	How often	For:

Please list all other medicines and supplements, and the conditions for which you take them:					
Name	Dose	For:	Name	Dose	For:

Please list any allergic reactions you have to medications, food, etc.:	☐None
Name	Reaction

REVIEW OF SYSTEMS: Have you experienced any of these symptoms recently?	
YES	Symptom
	FATIGUE
	FEVER
	NIGHT SWEATS
	HEARING LOSS
	COUGH
	WHEEZING
	CHEST PRESSURE OR DISCOMFORT
	IRREGULAR HEARTBEAT/PALPITATIONS
	CONSTIPATION
	DIARRHEA
	VOMITING
	DYSURIA (PAIN OR BURNING ON URINATION)
	HEMATURIA (BLOOD IN URINE)
	COLD INTOLERANCE
	HEAT INTOLERANCE
	POLYDIPSIA (INCREASED THIRST)
	POLYPHAGIA (INCREASED APPETTITE)
	POLYURIA (FREQUENT URINATION)
	DIZZINESS
	GAIT DISTURBANCE (TROUBLE WALKING)
	HEADACHE
	EMOTIONAL CHANGES
	RASH
	ARTHRALGIAS (PAINFUL JOINTS)
	JOINT SWELLING
	MUSCLE WEAKNESS
	BLEEDING
	BRUISING
	ENVIRONMENTAL ALLERGIES
	FOOD ALLERGIES

Have you had any of the following?			
Please check Yes or No and add details, such as duration and the name of any specialist treating you:			
Yes	No	Description	Notes
		Arthritis	
		Asthma	
		Blood Clots	
		Cancer (Please write type and management in notes section)	
		COPD	
		Diabetes	
		Heart Disease	
		Hepatitis/Liver Disease (Type:)	
		High Blood Pressure (Hypertension)	
		Renal Disease (Please write type and management in notes section)	
		Seizure Disorder	
		Stroke	
		Thyroid Disease	
		Sleep Apnea	
		Home Oxygen Therapy	
		Tuberculosis	
		Treatment to Thin Your Blood	
		Sexually Transmitted Disease	
		Stomach Ulcers/Colitis	
		Immune System Disorder	
		Anemia	
		Blood Transfusion	

Please list any major operations, hospitalizations, or injuries: ☐None (skip to next section)	
Date	Event

Please indicate if these illnesses occurred amongst your relatives: ☐ No information available							
Description	None	Father	Mother	Sister	Brother	Children	Grandparents
Retinal Detachment							
Retinal Disease							
Macular Degeneration							
Blindness							
Glaucoma							
Cataract							
Eye Tumor							
High Blood Pressure							
Heart Disease							
Diabetes							
Cancer							
Migraine							

Do you smoke tobacco? ☐Never
☐Quit How old were you when you quit? _____ How much in the past? _____
Type: ☐ Cigarettes ☐ Cigars ☐ Cigarillos ☐ Pipes
☐Yes How much currently? _____
Type: ☐ Cigarettes ☐ Cigars ☐ Cigarillos ☐ Pipes

Do you drink any alcohol? ☐None ☐Daily ☐Weekly ☐Monthly ☐Yearly
☐Occasionally ☐Rarely ☐Socially

Your occupation: _____ (☐ Retired)

Have you used any recreational drugs recently? ☐Never ☐No ☐Yes Type:_____

Do you have diabetes? ☐No ☐ Yes Year of onset: _____ ☐Type I ☐ Type II
Last Fasting Blood Sugar: _____(date) _____ (time)
Last HbA1c result: _____ Date of test: _____

Please list all previous surgery, laser, or drug treatment ***for your eyes:*** ☐None	
Date	Indicate which eye, the name of the surgeon, and the reason for the procedure:

I have answered these questions as completely as possible.

Signature: Date:

****

If you have completed this form on behalf of the patient, please print your name and relationship to the patient below.

Name: Relationship:

Retina Northwest Payment Policy

Thank you for choosing Retina Northwest for your medical care. We are committed to providing you with quality, personal health care and appreciate your commitment to adhere to our payment policy agreement.

Patients are expected to provide identification and a current insurance card(s) at time of service. We will bill your insurance when you provide us with current information. We bill insurance in accordance with all federal, state, and other contractual requirements in cases where we have an agreement or we are a participating provider. Please keep in mind that payment remains your responsibility. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance of your account. Your insurance company will determine what amount, if any, you owe to Retina Northwest.

All accounts are due and payable within 30 days unless special arrangements are made with our Business Office.

For your convenience, we accept cash, money orders, checks, Visa, MasterCard, American Express, and Discover.

Attestation Statement:

I have read, understand, and agree to the above Retina Northwest Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, and deductibles are my responsibility. I understand that delinquent accounts may be assigned to a collection service.

I authorize that my insurance benefits be paid directly to Retina Northwest.

I authorize Retina Northwest to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.

_____ _____

Signature Date

_____

Printed Name

RETINA NORTHWEST, PC

PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I understand that Retina Northwest (RNW) will use and disclose health information about me.

I have received a copy of RNW's Notice of Privacy Practices, effective September 23, 2013. This notice describes how RNW and its physicians, employees, staff and other office personnel may use and disclose health information about me. It explains my rights with respect to my health information and how I can exercise these rights.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon my request.

By signing below, I agree that I have reviewed and understood the information and that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____ DOB: _____

Description of Patient Representative's Authority (if not signed by patient)_____

Release of Information Authorization

Many patients have a spouse, relative(s) and/or friend(s) who helps with and is involved in their medical care. In order for us to share information about your care with these people, we need a release from you. Please list below those people with whom we can discuss your medical care, including your appointments, medical conditions, recommended treatments, and account payment arrangements.

Name	Birthday	Relationship	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____

Patient Signature Date DOB

Retina Northwest, PC

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information below. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter **to 200 Independence Avenue, S.W., Washington, D.C. 20201**, calling **1-877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Retina Northwest, PC

2525 NW Lovejoy Street, Suite 300

Portland, OR 97210

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** We give information about you to your health insurance plan so it will pay for your services.

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

RETINA NORTHWEST, P.C.

PATIENT PORTAL ANNOUNCEMENT:

Retina Northwest, P.C. is pleased to announce that we have a secure Patient Portal now available thru NextMD.com. The Patient Portal feature uses leading edge technology to allow you secure and convenient access to your medical information from the comfort and privacy of your own home or office (similar to an online bank account, but for your medical chart).

Once enrolled, you will be given a secure enrollment "token" you can use to activate your account. With your account activated you will be able to:

- **Pay your bill online** (after you receive your 1st electronic statement)
- **Send non-urgent and secure messages to our office staff to:**
  - Ask non-urgent medical / medication questions relating to your care
  - Inquire about your bill and payments
  - Inquire about your future appointments
- **View your Personal Health Record:** which includes a list of your allergies, conditions, medications, procedures, vital signs, and family history, as well as other health information.
- **Request copies of your chart notes and your Patient Plan**

After initiating the enrollment process in one of our clinics, you will receive an email directing you to use the "token" provided (which will allow you to create your own username and password) and complete the enrollment process. If you need assistance, please call our office at (503) 274-2121 or (800) 654-7765 and ask for the portal help desk.

Please see any of our clinic receptionists, or call our office at (503) 274-2121 to initiate your enrollment today.

RETINA NORTHWEST, P.C.

RNW Automated Appointment Reminders Form

I, _____ (patient name), elect to enroll in Retina Northwest's automated messaging system effective on the date signed below. I understand that I will receive automated messages from the practice regarding my future appointments.

I would like to receive automated messages via (check all that apply):

- ☐ **Text; sent to this cell phone number : _____**
- ☐ **Voice; sent to this phone number:_____**
- ☐ **Email; sent to this email address : _____**

By signing below, I confirm that I understand this consent and enrollment form.

Name (print full name):_____

Signature:_____

Date:_____