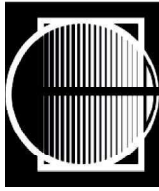


\_\_\_\_\_



# 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: \_\_\_\_\_

<p>Race:</p> <p>___ American Indian or Native American</p> <p>___ Asian</p> <p>___ Black or African American</p> <p>___ Native Hawaiian or Pacific Islander</p> <p>___ White</p> <p>___ Declined to Answer / Not reported</p>	<p>Ethnicity:</p> <p>___ Hispanic or Latino</p> <p>___ Not Hispanic or Latino</p> <p>___ Declined to Answer / Not reported</p> <p>Preferred Language: _____</p>
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**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:

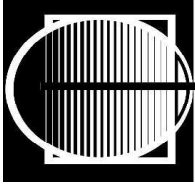
Insurance Company Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber's Sex M/F

Relationship to Patient \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

<p>Which Doctor Referred You to Retina Northwest?</p> <p>_____ M.D.        _____ O.D.        _____ D.O.</p> <p>First Name Last Name</p> <p>Address City State Zip</p> <p>Phone# ( ) - _____  <small>Area Code</small></p>	<p>Who is Your Primary Care Physician?</p> <p>_____ M.D.        _____ D.O.</p> <p>First Name Last Name</p> <p>Address City State Zip</p> <p>Phone# ( ) - _____  <small>Area Code</small></p>
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RETINA NORTHWEST, P.C.

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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 only one):

**Text; sent to this cell phone number:**

**Voice; sent to this phone number:**

**Email; sent to this email address:**

**Decline; I do not wish to receive appointment reminders**

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

Name (full name): \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# RETINA NORTHWEST, PC

## PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I understand that Retina Northwest, PC (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 (see following pages). 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 those 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.

### 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 Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Description of Patient Representative's Authority (if not signed by patient): \_\_\_\_\_

**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 bill insurance in accordance with all federal, state, and other contractual requirements. 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.

Self Pay Patients: A \$400 deposit is required at the beginning of your initial visit. A \$250 deposit is required at the beginning of any subsequent visits. You may have a balance left over after the deposit. If you are receiving an injection, the payment of the drug is required at the beginning of each visit in addition to the \$250.00

No Show Appointments: Failure to provide advanced notice to cancel your appointment may result in a “no show” fee of \$75.00. Notice of cancellation must be done 1 full business day prior to the appointment.

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.*

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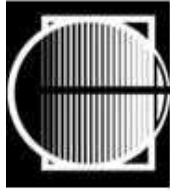
PRINTED NAME

**X**

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PATIENT SIGNATURE

DATE



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  Other:

Your Primary Care Provider:
Your General Eyecare Provider:

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

Do you have any other healthcare providers?	
Cardiologist <input type="checkbox"/> No <input type="checkbox"/> Yes	Name & Phone Number:
Endocrinologist <input type="checkbox"/> No <input type="checkbox"/> Yes	Name & Phone Number:
Other(s): <input type="checkbox"/> No <input type="checkbox"/> Yes	Name(s) & Phone Number(s):

Do you wear corrective lenses?	<input type="checkbox"/> No	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contact lenses
--------------------------------	-----------------------------	----------------------------------	---

Do you have any of the following vision changes?			
Description	No	Right Eye	Left Eye
Distortion			
Blurring			
Dimness			
Blind spot or area			
Flashes or flickering			
Floaters			
Severe light sensitivity			
Other:			

Do you have Diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes	Year of onset: _____	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II
Last Fasting Blood Sugar: _____ (date)			
Last HbA1c result: _____		Date of test: _____	

Do you have any of the following?					
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
All other medical conditions:					

Please list any eye drops, medications, and supplements that you take <b>for your eyes:</b>					
<b>Right Eye</b>			<b>Left eye</b>		
Name	Dose	For:	Name	Dose	For:

If you did not bring a medication list...

Please list <b>ALL</b> other medications and supplements, and the conditions for which you take them:					
Name	Dose	For:	Name	Dose	For:

Please list any <b>allergies</b> to medications: <input type="checkbox"/> None	
Name	Reaction

Please list all previous **EYE** surgeries, lasers, or drug treatments: None

Date	Event

Please list any major surgeries, hospitalizations, or injuries: None

Date	Event

Do you have any family history of:	None	Mother	Father	Sibling	Grandparent	Children
Retinal Detachment						
Macular Degeneration						
Unexplained Blindness						
Glaucoma						

Do you use tobacco? Never

Quit    How old were you when you quit? \_\_\_\_\_    How much in the past? \_\_\_\_\_

          Type:    Cigarettes        Cigars            Pipes            Vape

Yes    How much currently? \_\_\_\_\_

          Type:    Cigarettes        Cigars            Pipes            Vape

Do you drink any alcohol?    None    Daily    Weekly    Monthly    Yearly

Have you used any recreational drugs recently?    Never    No    Yes    Type: \_\_\_\_\_

Your occupation? \_\_\_\_\_ Retired

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, PC

Notice of Privacy Practices

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## **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.

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## 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.

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#### 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.

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#### 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.

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#### 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.

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#### 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.

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**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.

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**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.

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**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.

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**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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.

- We will not retaliate against you for filing a complaint.

**Retina Northwest, P.C.**

**4225 NE St. James Rd**

**Vancouver, WA 98663**

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## 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.*

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**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.

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<b>Treat you</b>	<ul style="list-style-type: none"><li>• We can use your health information and share it with other professionals who are treating you.</li></ul>	<b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.
<b>Run our organization</b>	<ul style="list-style-type: none"><li>• We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li></ul>	<b>Example:</b> We use health information about you to manage your treatment and services.
<b>Bill for your services</b>	<ul style="list-style-type: none"><li>• We can use and share your health information to bill and get payment from health plans or other entities.</li></ul>	<b>Example:</b> We give information about you to your health insurance plan so it will pay for your services.

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*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](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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#### 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

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#### Do research

- We can use or share your information for health research.

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#### 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.

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#### Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

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**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.

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**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

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**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.

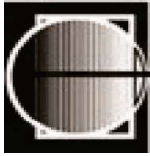
- 
- We are required by law to maintain the privacy and security of your protected health information.
  - We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
  - We must follow the duties and privacy practices described in this notice 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](http://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.

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## PATIENT PORTAL ANNOUNCEMENT:

Retina Northwest, P.C. is pleased to announce that we have a secure Patient Portal now available through [MyPatientVisit.com](http://MyPatientVisit.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).

You will be sent an invitation to enroll in the portal via email or text message. With your account activated you will be able to:

- **Pay your bill online** (after you receive your 1<sup>st</sup> 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 create a login 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.