NRI THE NATIONAL RETINA INSTITUTE
A KATZEN EYE GROUP PRACTICE

Welcome

Dear Patient,

Thank you for choosing the doctors and staff at The National Retina Institute for your care. Please know that we pride ourselves in offering hope, compassion, and the most innovative treatment and technology available in the area.

Enclosed you will find your appointment care, Patient Information and Medical History Forms. Please bring these completed forms with you at the time of your appointment. In addition, please bring your insurance card(s) as they must be scanned into our computer system. If your insurance is an HMO, please obtain the appropriate referral for your appointment from your primary care provider.

Please be prepared to spend approximately 2-4 hours for your first appointment depending on your diagnosis and possible testing and treatment performed that day. Both of your eyes will be dilated as part of the exam, therefore you should bring sunglasses for your ride home. If you are uncomfortable driving while dilated, you may want to have someone accompany you to the appointment.

We ask that you please limit the number of people that you bring with you to your appointment due to the limited seating that we have available for our patients.

If you have any question or need additional information, please call our office at **410-337-4500** so that we can assist you.

Sincerely,
The National Retina Institute

6325 Woodside Court Suite 125 Columbia, MD. 21046 Phone: 410-919-4455 Fax: 410-210-4013

www.nationalretina.com

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Patient Information Form

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Social Security No: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M F

Employer: _____ Work Phone: _____

Employer Address: _____ Occupation: _____

Spouse/Parent Name: _____ Phone No: _____

Emergency Contact Person: _____ Date of Birth: _____
(Someone not living with you)
Emergency Contact Phone: _____ Relation/Role To Patient: _____

Primary Insurance: _____ Policy No: _____ Group No: _____

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Policyholder's Social Security No: _____

Secondary Insurance: _____ Policy No: _____ Group No: _____

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Policyholder's Social Security No: _____

Family Physician: _____ Phone No: _____

Full Address: _____

Optometrist/Ophthalmologist: _____ Phone No: _____

Full Address: _____

Referring Doctor: _____ Phone No: _____

Full Address: _____

I hereby authorize The National Retina Institute (NRI) to bill my insurance (which may include release of medical information to process this claim). I also authorize payment to be made directly to NRI. In addition, if my account is forwarded to an outside collection agency for collection of a past due balance, I will be responsible for the collection fees incurred by NRI to said outside collection agency. ***YOUR SIGNATURE IS REQUIRED BELOW.***

Signature: _____ Date: _____

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Medical History Questionnaire

Name _____ **Date of Birth** _____

Date of last eye examination: _____ **Today's Date** _____

Do you have **ALLERGIES** to any medication? _____ YES _____ NO If YES, please list:

	Medication (Allergic To):	**Symptoms**
1.		
2.		
3.		
4.		

Illnesses Past and Present	**YES**	**NO**	**Duration**	**Family History**	**YES**	**NO**	**Relationship**
Glaucoma				Glaucoma			
Arthritis				Arthritis			
Cancer				Cancer			
Diabetes				Diabetes			
Heart Disease				Heart Disease			
High Blood Pressure				High Blood Pressure			
Kidney Disease				Kidney Disease			
Stroke				Stroke			
Thyroid Disease				Thyroid Disease			
Asthma				Asthma			
Hay Fever or Sinus				Hay Fever or Sinus			
Emphysema				Emphysema			
Other				Other			

List any **eye surgeries** you have had (cataract, corneal transplant, etc.)

List any **surgeries** you have had (appendectomy, tonsillectomy, etc.)

Do you drink alcohol? ____ YES ____ NO If yes, how many drinks per week? _____

Have you ever had a blood transfusion? ____ YES ____ NO If yes, what year? _____

Do you drive? ____ YES ____ NO

Do you currently have any problems in the following areas? If **YES**, please provide information.

Review of Systems (examples)	YES	NO	Explanation of Problem
EYES (glaucoma, cataracts, blurred vision)			
GENERAL (fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR (chest pain, palpitations)			
RESPIRATORY (cough, shortness of breath, wheezing)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
MUSCULOSKELETAL (joint pain, muscle weakness or pain)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
ENDOCRINE (diabetes, hypothyroid)			
HEMATOLOGIC (anemia, bleeding or bruising tendencies)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus)			

OFFICE USE ONLY:

History reviewed: _____ ***No*** _____ ***Yes*** _____ ***Changes as noted above***

Date: _____ ***Technician's Signature:*** _____

Rev 2019

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

_____ _____

Patient Name (print) Date of Birth

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to The National Retina Institute for services furnished me by The National Retina Institute. I authorize any holder of medical or other information about me to release such information to Medicare so a determination of my benefits may be made. The National Retina Institute accepts the payment determination of the Medicare carrier as payment in full from Medicare, and I am responsible only for the deductible, coinsurance and non-covered services.

2. MEDIGAP: I request that payment of authorized secondary insurance benefits be made on my behalf to The National Retina Institute, if possible or otherwise to me. I understand and agree that I am responsible for any co-payment or deductible set by my Medigap policy. I authorize any holder of medical or other information about me to release such information to the insurer so a determination of my Medigap benefits may be made.

3. RELEASE OF INFORMATION: The National Retina Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to The National Retina Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. The National Retina Institute may also disclose any information considered to be de-identified under the HIPAA Privacy Standards, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data.

4. OTHER INSURANCE: I understand that The National Retina Institute contracts with a number of health care service plans. A list of such plans is available from the business office. The National Retina Institute does

not have a contract, expressed or implied, with any plan that does not appear on the list. I understand and agree that I am obligated to pay the full charges of all services rendered to me by The National Retina Institute if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that The National Retina Institute contracts with health care service plans (i.e., HMOs, PPOs) that state items and services which are "covered" by the health care service plans. These health service plans will not pay for items or services that fall outside its coverage rules. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. I understand and agree that it is my responsibility to obtain necessary health care service plan authorizations. Further, I also understand and agree that I am obligated to pay the full charges of all services rendered to me by The National Retina Institute if the services are not covered by my health plan.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by The National Retina Institute, I will pay my account at the time service is rendered or will make other arrangements for payment that are satisfactory to The National Retina Institute. If, for any reason, The National Retina Institute must send my account to an attorney for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

X_____ _____

Beneficiary Signature or Authorized Party Date

I ACKNOWLEDGE RECEIPT OF NRI'S NOTICE OF PRIVACY PRACTICES.

X_____

DATE_____

PATIENT MEDICATION LIST

DATE:_____

PATIENT NAME: _____

DATE of BIRTH:_____

☐ **CHECK HERE IF A COPY OF YOUR MEDICATION LIST HAS BEEN PROVIDED DURING THIS VISIT.**

MEDICATION	DOSAGE	HOW IS IT TAKEN?	HOW MANY TIMES A DAY?
Example: Pravastatin	20 mg	by mouth	every evening
			Rev 12/2019

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

All fields on this authorization must be completed in full, or the request will not be honored.

I understand that I may revoke this authorization in writing at any time.

A fee for copying, not to exceed $0.76 per page, is due upon request.

Patient Name: _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Phone Number:** _____

I, _____, do hereby authorize THE NATIONAL RETINA INSTITUTE, to release my protected health information to:

- **NAME:** _____
  ADDRESS: _____
  CITY: _____ **STATE:** _____ **ZIP:** _____
  PHONE #: _____ **FAX #:** _____
- **NAME:** _____
  ADDRESS: _____
  CITY: _____ **STATE:** _____ **ZIP:** _____
  PHONE #: _____ **FAX #:** _____

I authorize the release of my health information from:

- **NAME:** _____
  ADDRESS: _____
  CITY: _____ **STATE:** _____ **ZIP:** _____
  PHONE #: _____ **FAX #:** _____

Exam notes released includes dates of service from _____ to _____.

The purpose for such disclosure is:

___ **At my request (only patient may check). R*equest expires one year from date of original request.***

___ **Other** _____

_____ _____

Patient's / Legal Representative's Signature **Date**

(must provide legal documentation)

6325 Woodside Court ● Suite 125 ● Columbia, MD 21046 ● Phone: 410-919-4455 ● Fax: 410-210-4013

www.nationalretina.com

PATIENT DATA FORM

FULL NAME: _____ **DATE:** _____

MARITAL STATUS: _____

OCCUPATION: _____

ETHNICITY: (circle one)

- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO
- UNKNOWN / NOT REPORTED
- DECLINE TO SPECIFY

RACE: (circle one)

- AMER. INDIAN OR ALASKA NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- HISPANIC
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- WHITE
- OTHER
- DECLINE TO SPECIFY

PREFERRED LANGUAGE: (circle one)

- ENGLISH
- SPANISH
- OTHER:_____
- DECLINE TO SPECIFY

TOBACCO USE:	**HAVE YOU EVER USED TOBACCO? YES NO /NEVER FORMER**
IF YES, WHAT KIND OF TOBACCO:	**Cigarette Cigarillo Cigar Pipe Chewing Smokeless Snuff**
USAGE PER DAY:	

FALLS RISK:	
FALLS IN LAST YEAR:	**YES NO**
# OF FALLS IN LAST YEAR:	
DID INJURY RESULT?	**YES NO**
INJURY DETAILS:	

PHARMACY:	
NAME:	
ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	

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NEXTGEN PATIENT PORTAL

What is the Online Patient Portal?

The Online Patient Portal is a secure, intuitive website that enable patients and providers to quickly access and manage health information. It provides easy communication tools, promoting patient-provider interaction and improving patient care.

With the Online Patient Portal, soon you will be able to:

- Quickly and securely access your health information
- Instantly request and schedule appointments
- Send secure messages to billing clinical staff
- Easily request prescription refills
- Reduce wait time by filling out form online

Enroll now for FREE! It's easy as 1, 2, 3!

1. An NRI staff member will offer you an Enrollment Token during your visit.
2. Visit www.NextMD.com
3. Click **Enroll Now** and simply follow the steps.

YOUR ENROLLMENT TOKEN IS: _____

NextGen Patient Portal Enrollment

[ ] I **accept** enrollment in the NextGen Patient Portal ***(must provide email address)***

Email address: _____

[ ] I **decline** enrollment in the NextGen Patient Portal at this time

PRINT Patient Name: _____ Date: _____