

RETINA-VITREOUS CONSULTANTS

STEVEN B. COHEN, M.D.

ERIC D. KANTER, M.D.

Practice Limited to the Diseased and Surgery of the Retina and Vitreous

Macular Degeneration Center Of New Jersey
Institute For Treatment of Diabetic Eye Disease

NEW PATIENT INFORMATION AND INSTRUCTIONS:

1. Please review and complete all enclosed forms. If you have access to a fax you may fax them ahead of time to 973-716-0441. If you are unable to fax them in simply bring the completed forms with you to your appointment.
2. Please arrive 20 minutes early for your appointment to allow time for us to prepare your chart.
3. Please to bring the following with you to your appointment:
 - Your completed forms
 - **All** insurance cards
 - Photo ID
 - Copy of your most recent blood work
4. If you have an HMO or POS insurance policy which requires a referral you must obtain one from your primary care physician prior to your appointment. It is your responsibility to make sure we have received it. If one is not obtained your visit may have to be rescheduled or you will be asked to sign a wavier and will be responsible for any remaining balances.
5. If you have seen another retinal specialist in the past or are coming for a second opinion it is important that you have your medical records transferred in advance so that the doctor can review your file ahead of time.
6. We do recommend that you bring a driver with you to your appointment since your eyes will be dilated when you leave our office.
7. It is a good idea to bring a pair of sunglass with you since the dilation will make your eyes sensitive to the sun.

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www.rvc-nj.com

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Patient Name: _____ Sex: M F
(First) (M) (Last)

D.O.B. ____ / ____ / ____ Age: _____ S.S # ____ - ____ - ____

Home Address: _____
(Street) (City) (Zip)

Home Phone : _____ Cell Phone: _____

Email Address: _____ Marital Status: S M D W

May we leave a message if we are unable to reach you that may contain personal information? Y N

Employer: _____ Phone: _____

Employer Address: _____
(Street) (City) (Zip)

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Do you have an Advanced Directive? Y N If so, please provide copy for our records

INSURANCE INFORMATION

<u>PRIMARY :</u>	<u>SECONDARY:</u>
Insurance Company: _____	Insurance Company: _____
ID # _____	ID # _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber D.O.B: _____	Subscriber D.O.B: _____
Subscriber SS# : _____	Subscriber SS# : _____
Relationship to Patient: _____	Relationship to Patient: _____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: _____ Do you authorize this person to have full access to your medical information and records? Y N

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT AN INTEREST of 1.5% and a \$15.00 collection fee MAY BE CHARGED on all balances owed to the provider that are past due.

Signature: _____ Date: ____ / ____ / ____
(signature of insured or authorized person, patient, or parent if minor)

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Patient Medical History and Review of Systems

Patient Name _____ Date of Birth _____

Ocular History

Glaucoma	Y	N
Macular Degeneration	Y	N
Diabetic Eye Disease	Y	N
Retinal Detachment	Y	N

Neurological

Stroke	Y	N
Seizures	Y	N
Multiple Sclerosis	Y	N
Headaches	Y	N

Eye Surgery or Laser Treatment:

Urinary

Prostate Disease	Y	N
Renal Failure	Y	N

Family Ocular History

Glaucoma	Y	N
Macular Degeneration	Y	N
Diabetic Eye Disease	Y	N
Retinal Detachment	Y	N

Musculoskeletal

Rheumatoid Arthritis	Y	N
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Psychiatric

Dementia	Y	N
Alzheimer's	Y	N
Depression	Y	N

Endocrine

Thyroid	Y	N
Type 1 Diabetes	Y	N
Type 2 Diabetes	Y	N

Last Blood Sugar: _____
Last Hemoglobin A1C: _____

Cancer

	Y	N
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If yes, type: _____

Cardiovascular

Palpitations	Y	N
High Blood Pressure	Y	N
Heart Attack	Y	N
Pacemaker	Y	N
Carotid Artery Disease	Y	N
Angioplasty/Bypass	Y	N
Elevated Cholesterol	Y	N

Respiratory

Asthma	Y	N
Emphysema	Y	N
Tuberculosis	Y	N

Hematologic

Anemia	Y	N
Sickle Cell	Y	N

Social History

Smoking

Packs per day _____
Number of Years _____
When quit _____

Alcohol

social ___ occasional ___ heavy ___

Immunology

Immune Deficiency	Y	N
Lupus	Y	N
HIV/AIDS	Y	N
Sarcoidosis	Y	N

Please list all surgical procedures and year

Gastrointestinal

Hepatitis	Y	N
Gallbladder	Y	N
Inflammatory Bowel Disease	Y	N

Drug Allergies

Reviewed with Patient: _____

Date Reviewed: _____

OVER -->>

Retina- Vitreous Consultants

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Eric D. Kanter M.D.

Chart # _____

Please list ALL of your Physicians and Specialists

Name & Specialty	Address	Phone and Fax Number

Please list ALL of the medications that you are currently taking.

(Including: Prescriptions, Vitamins, Herbs, and over the counter medications including Aspirin & Pain relievers)

Drug Name & Dosage	Drug Name & Dosage	Eye Medications & Frequency

Your Pharmacy _____ Pharmacy Phone # _____

Patient Signature _____ Date _____

**Retina-Vitreous Consultants
Livingston Vitreo-Retinal Associates, PA**

NOTICE OF PRIVACY PRACTICES

**Date of Last Revision: September 13, 2004
Effective Date: Immediately**

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.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes Retina-Vitreous Consultants/Livingston Vitreo-Retinal Associates policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, technicians, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff, and other personnel that work for or with our Practice;
- Our business associates, on-call physicians, and so on.

The Practice provides this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the service and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- Make sure that the protected health information about you is kept private;
- Provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- Follow the conditions of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or

disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- **Medical Treatment-** We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore, we may disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the practice also may share medical information about you including your record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the practice who may be involved in your medical care after you leave the practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).
- **Payment-** We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.
- **Health Care Operations-** We may use and disclose medical information about you so that we can run our practice more efficiently and make sure that all our patients receive quality care. These uses may include reviewing our treatment and service to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates so they can perform the job we've asked them to perform, to auditors to verify our records, and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

- **Appointment and Patient Recall Reminders-** We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the practice or that you are due to receive periodic care from the practice. This contact may be by phone, a message on the answering machine, or otherwise that could potentially be received or intercepted by others.
- **Research-** Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.
- **Notification of Family-** We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.
- **Communication With Family-** We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.
- **Required By Law-**We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health and Safety-**We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.
- **Worker's Compensation-** We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Victims of Abuse, Neglect, or Domestic Violence-** We may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.
- **Public Health Risks-** Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
 - To report births and deaths;
 - To report child abuse or neglect;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Investigation and Government Activities-** We may disclose medical information to a local, state, or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.
 - **Lawsuits and Disputes-** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.
 - **Law Enforcement-**We may release medical information if asked to do so by a law enforcement official.
 - **Inmates-** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the practice for treatment or health services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our Compliance Officer, Alice Taipina R.N., who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

The Compliance Officer can be reached at (973) 716-0123.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy** – You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.
- **Right to Amend**- If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

**RETINA-VITREOUS CONSULTANTS
LIVINGSTON VITREO-RETINAL ASSOCIATES**

I understand that professional services are rendered to the patient and that patient is responsible for the charges incurred. I understand that I am financially responsible for the charges not covered by my insurance company. I understand that the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I understand that any balance left unpaid will be subject to an interest rate of 1.5% monthly and a \$15.00 Collection Fee.

Signature _____

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his medical judgment.

Initial _____

I acknowledge that I have received a copy of Retina-Vitreous Consultants Privacy Act.

Initial _____

I hereby authorize the following people to have full access to my medical information and records:

I hereby give permission for the office to contact the following people regarding any financial questions that may arise during the course of my treatment:

By my signature below, I acknowledge that I have received Retina-Vitreous Consultants/Livingston Vitreo-Retinal Assoc. Notice of Privacy Practices and I authorize the release of my private healthcare information for the purposes of treatment, payment and healthcare operations.

Name (print)

Signature

Date