Wyoming Retina Associates, PC
WELCOME TO OUR PRACTICE

Please complete all sections below and read our financial policy, then sign and date.
We thank you for your cooperation.

Date _______________

_________________________ ______________________________ _______ _____________
Last Name First Name Initial Nickname

_____________________________________ _______________________ ______ ________________
Address City State Zip Code

Date of Birth: ______________ Age: _______ SS#: __________________________ Sex: F M

Home Phone: __________________ Cell Phone: _________________ Other Phone: _________________
Can we leave a message Y N **Can we leave a message Y N** **Can we leave a message Y N**

Marital Status: S M D W Spouse's Name: ___________________ Email Address: ___________________

Employer: _______________________ Occupation: ____________________ Work Phone: _______________

Race ____________________ Ethnicity: _______________ Height: ________ Wt: _________

First Insurance:

____
Insurance Name

Ins ID #_________________ Group # ___________

Subscriber Name: ____________________________

Subs. SS #:__________________ DOB ___________

Second Insurance:

____
Insurance Name

Ins ID #___________________ Group #_____________

Subscriber Name: ________________________________

Subs. SS #:____________________ DOB _____________

Worker's Comp Info: Y N Work Comp Carrier: _______________________ Date of Accident: _________

Claim #: _______________ Contact Name & Phone No. ____

Referring/Primary Physicians:

Reason for Visit: _____________________________________

____________________________ ________________ _______________________________________
Referring Eye Doctor/Optometrist Phone Number Address/Location

____________________________ ________________ _______________________________________
Primary Care Doctor Phone Number Address/Location

In Case of Emergency:

Person to Contact: ____ Relationship: _______________________

Home Phone: __________________ Cell Phone: _________________ Other Phone: _________________
Can we leave a message Y N **Can we leave a message Y N** **Can we leave a message Y N**

Financial Policies and Authorizations

Please read the following information before seeing the doctor to eliminate any confusion regarding our office financial policy.

MEDICARE: Our doctor is participating with Medicare. We will be happy to submit any claims to Medicare and any Medigap claims **one time** for you. If you do not have any secondary or supplemental coverage, you will be responsible for the 20% of what Medicare does not cover.

MEDICAID: Our doctor is participating with Medicaid; we will file claims for you. You will be expected to pay any co-pays **AT THE TIME OF VISIT**.

HMO & PPO: We will file claims for you **once**. You will be responsible for any co-pays, deductibles or services not covered at the time of your visit. ***If your plan requires a referral/authorization from your primary care physician, you will be responsible for obtaining this prior to your visit.***

TRICARE: As of 1/1/2018 we will no longer bill TRICARE as primary. Therefore, the patient will be responsible for payment in full the day of the service.

PRIVATE PAY: You will be responsible for payment **IN FULL THE DAY OF SERVICE**. Please call our billing department for information at 307-237-3740.

Insurance Signature Authorization

I authorize release of information for all of my insurance submissions and authorize WRA to act as my agent to secure payment from the insurance company. I authorize payment directly to WRA and permit a copy of this authorization to be used in place of the original. I understand, that I am financially responsible for bills submitted and for any balance not paid by insurance

Patient acknowledgement and consent of notice of Privacy Practices for Protected Health Information; I have received a copy of Notice of Privacy Practices for Protected Health Information. I grant consent to Wyoming Retina Associates, P.C.: to use or disclose my personal health information to carry out treatment, payment or health care operations as described in the Notice of Privacy Practices for Protected Health Information.

I have read the above financial policy, Medicare/Insurance signature Authorization, and Patient Acknowledgement & Consent of Notice of Privacy Practices for Protected Health Information completely; I understand and accept this policy.

X____

Signature of Patient Printed Name Date

For Minors:
I, ___________________________________, give my permission for Wyoming Retina Associates, P.C. to treat my child, ____.

Signature of Parent/Guardian ____

Wyoming Retina Associates, PC **Patient History Record**

Date: ________________________

Past Medical History

Do you have or have you been treated for:

Diabetes	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐
Heart Disease (MI/irreg. beat)	Y ☐	N ☐
Lung Disease (Asthma, COPD)	Y ☐	N ☐
GI/Colitis/Liver Disease	Y ☐	N ☐
Neuro Disease/Stroke	Y ☐	N ☐
Vascular Disease	Y ☐	N ☐
Arthritis	Y ☐	N ☐
Cancer	Y ☐	N ☐
Bleeding Disorder/Anemia	Y ☐	N ☐
HIV/AIDS/STD	Y ☐	N ☐
Kidney Disease/Dialysis	Y ☐	N ☐
Thyroid	Y ☐	N ☐

If yes, please explain (duration, treatment, hospitalization, and surgery/date):

Systemic Medications (or attach list)

Please list name, dosage, frequency:

Medical Allergies

Past Surgical History

Please list all past surgeries and/or injuries:

Eye Disease/Surgery

Do you have or have you been treated for:

Retinopathy (Diabetes, High Blood)	Y ☐	N ☐
Macular Degeneration	Y ☐	N ☐
Macular Edema	Y ☐	N ☐
Macular Hole	Y ☐	N ☐
Retinal Vein Occlusion	Y ☐	N ☐
Vitreous floaters	Y ☐	N ☐
Vitreous Hemorrhage	Y ☐	N ☐
Retinal Tear	Y ☐	N ☐
Retinal Detachment	Y ☐	N ☐
Cataract	Y ☐	N ☐
Glaucoma	Y ☐	N ☐
Infection	Y ☐	N ☐
Inflammation	Y ☐	N ☐
Strabismus/Amblyopia	Y ☐	N ☐
Dry Eyes	Y ☐	N ☐
Corneal Disease	Y ☐	N ☐
Other	Y ☐	N ☐

If yes, please explain (duration, treatment, surgery)

Ocular medications – Please list name, dosage, frequency

Family and Social History – Do any medical or eye diseases run in your family?

Do you smoke? Y N How much? ______ Do you drink alcohol? Y N How much? __________

Wyoming Retina Associates, PC **Patient History Record**

Date: ________________________

Review of Recent Symptoms:
Have you experienced the following symptoms recently? Please check "Yes" or "No"

Constitutional:

☐ Yes ☐ No Chills or Fever
☐ Yes ☐ No Unusual Fatigue
☐ Yes ☐ No Excessive Thirst
☐ Yes ☐ No Weight Change
☐ Yes ☐ No Pregnant

Ears, Nose, Throat, Mouth:

☐ Yes ☐ No Hearing Loss/Ringing
☐ Yes ☐ No Infection or Drainage
☐ Yes ☐ No Hoarseness
☐ Yes ☐ No Pain with Chewing

Neurologic:

☐ Yes ☐ No Muscle Weakness
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Seizures/convulsions
☐ Yes ☐ No Frequent Headache
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Loss of Balance

Bones and Joints:

☐ Yes ☐ No Painful or Stiff Joints
☐ Yes ☐ No Swelling of Joints
☐ Yes ☐ No Back or Neck Pain
☐ Yes ☐ No Cramps in Muscles

Skin:

☐ Yes ☐ No Itching
☐ Yes ☐ No Rash or Hives
☐ Yes ☐ No Change in Skin/Mole
☐ Yes ☐ No Scalp Tenderness

Heart:

☐ Yes ☐ No Racing/fluttering Heart
☐ Yes ☐ No Chest Discomfort
☐ Yes ☐ No Swollen Feet/ankles

Urinary:

☐ Yes ☐ No Pain or Burn on Urination
☐ Yes ☐ No Penile Discharge
☐ Yes ☐ No Blood in Urine
☐ Yes ☐ No Vaginal/Penile Ulceration

Lungs:

☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Wheeze/Asthma
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Cough

Gastrointestinal:

☐ Yes ☐ No Difficulty Swallowing
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Changes in stools
☐ Yes ☐ No Abdominal Pain

Mood:

☐ Yes ☐ No Memory change
☐ Yes ☐ No Change in Sleep
☐ Yes ☐ No Depression
☐ Yes ☐ No Excessive Worry
☐ Yes ☐ No Tense or Under Stress

Blood:

☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Prolonged Bleeding

I understand the above questions.
The answers given by me are correct to the best of my knowledge and belief.

Date: _____________ **Signature: X**____

Wyoming Retina
Associates, PC

Douglas L. Holmes, M.D.
307 S. Jackson St.
Casper, WY 82601
Phone: (307) 237-3937 Fax: (307) 237-0670

INFORMATION REGARDING DILATING EYE DROPS
AUTHORIZATION TO DILATE/PERFORM DIAGNOSTIC TESTS/TREAT

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Holmes and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

I further authorize Dr. Holmes and/or such assistants as may be designated by him to perform diagnostic tests that will be used to diagnose my condition. Additionally, I authorize Dr. Holmes to treat my condition.

____________________________________ ____________________
Patient (or person authorized to sign for patient) Date

____________________________________ ____________________
Witness Date

Patient Request for Disclosure of Protected Health Information

I ______________________________ authorize Wyoming Retina Associates, P.C. to release/discuss/schedule my personal health information/financial information to my following family members or contacts:

Name: ___________________________________ Phone: ___________________________

Relationship: ______________________ Okay to leave message Y N

Name: ___________________________________ Phone: ___________________________

Relationship: ________________________ Okay to leave message Y N

Name: ___________________________________ Phone: __________________________

Relationship: ________________________ Okay to leave message Y N

Name: ___________________________________ Phone: ___________________________

Relationship: ________________________ Okay to leave message Y N

I understand that this authorization will remain in effect until I give written notice of termination to Wyoming Retina Associates, P.C.

X____________________________________ ___________________________________

Patient Signature Date

X____________________________________ ___________________________________

Legal Guardian/POA Signature Date

ACKNOWLEDGEMENT OF HIPAA NOTICE

I HAVE RECEIVED A NOTICE OF THE Health Insurance Portability and Accountability Act, (HIPAA). HIPAA notice describes how my medical information may be used or disclosed. I understand that I should read it carefully. I am aware that the HIPAA notice may be changed at any time. I may obtain a revised copy of the HIPAA privacy practices by calling (307) 237-3937 or by requesting one at this office.

____________________ ____

Date Signature

____

Printed Name

As the representative of the above individual, I acknowledge receipt of the HIPAA privacy practices on their behalf.

____________________ ____

Date Signature

____

Relationship

Wyoming Retina Associates, PC

Douglas L. Holmes, M.D.
307 S. Jackson St.
Casper, WY 82601
Phone: (307) 237-3937
Fax: (307) 237-0670

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of: 9/23/2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of pr5otected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communication. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- Public health reporting and oversight activities
- Judicial, administrative, or law enforcement proceedings
- Complying with workers' compensation laws
- Communicating with your family or caregivers
- Sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations
- Inspect and copy your medical record
- Ask us to correct the information in your medical record
- Receive an accounting of disclosures of your PHI by our practice
- Be notified in the case of a breach of unsecured PHI

CONTACT US: Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your4 rights at Wyoming Retina Associates, PC 307 S. Jackson St., Casper, WY 82601