Valley Retina Institute, P.A.

PATIENT INFORMATION SHEET

Given to pt. _____
Ret. by pt. _____

Patient's name – First: _____ MI: _____ Last: _____

Date of birth: _____ Age: _____ Social Security #: _____ Sex: M □ F □

Address/Post Office Box: _____City_____ State_____

Home telephone: (____) _____ Cell #: (_____) _____ Other#: ( ) _____

In case of Emergency, please notify: _____ Relationship: _____ Phone #:_____

Patients Primary Physician: _____ City_____ Phone #: _____

Referring Physician: _____ City _____ Phone # _____

GUARANTOR INFORMATION

□ Self □ Spouse □ Mother □ Father □ Other --_If "Other", what is the relationship to the patient?_ _____

Responsible party's Name _____ Phone #: _____SS #: _____

Employer: _____ Work Phone# _____

Address: _____ City _____State _____

Insurance CO: _____Policy #:_____ _____

Workman's Comp. Ins.CO. _____Claim #: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy this authorization to be used in the place of the original. Release of information to family or friend: _____

Signature: _____ Date: _____

I hereby authorize Valley Retina Institute P.A. to apply for benefits on my behalf for covered services rendered by the physician or the physician's order. I request that payment from my insurance company be made directly to Valley Retina Institute P.A.

Notice of Privacy Practices: You have the right to read our Notice of Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about protected health information. A copy of our privacy statement is attached to the clipboard and is posted at the front desk. We certainly encourage you to read it carefully and ask questions about it if you need to before signing this consent.
We reserve the right to change our privacy policy as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain those changes. Those changes may apply to any of you protected health information that we maintain. You may obtain your own copy of our notice of Privacy Practices, including any revisions, by asking at the front desk.

Authorization to Pay Benefits to Physician: I accept full financial responsibility for all charges not covered by insurances and agree that if I do not present the correct insurance information on the date of service I will be fully responsible for all charges. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. *****There is a $35.00 fee for all returned checks. *****

Signature: I have had full opportunity to read and consider the contents of this Patient Information Sheet**.**

Signature: _____ Date: _____

If patient is under 18, consent must be signed by parent or legal guardian.

Parent or Legal Guardian: _____ Date: _____

VALLEY RETINA INSTITUTE, P. A.

Diseases and Surgery of the Retina and Vitreous

INFORMATION SHEET

You have been referred to Valley Retina Institute, P.A. Our doctors believe in comprehensive medical and surgical management of diseases of the retina and vitreous. We believe in providing personal state-of-the-art ophthalmologic care to our patients.

In order to further evaluate and confirm the diagnosis for which you have been referred it will be necessary for us to perform a series of tests. These tests are essential for the proper management of your vision. Please expect a 2-3 hour stay at our office to complete these studies.
Please follow these simple guidelines to assure that we can provide you with the best possible service:

- Your appointment will last between 2-3 hours depending upon the number of studies conducted.
- If possible make arrangement for someone to drive you home from your appointment, as both eyes will be dilated.
- If laser treatment is performed you will need to have someone drive you home from you appointment.
- Bring a pair of sunglasses with you or if you like a protective sunshade will be supplied.
- Advise us of all medications that you are taking and a brief medical history. Bring all your medications to each appointment. This includes medications taken for general health as well as eye medications.
- You should take your medication at your regularly scheduled time, as this will not interfere with our evaluation.
- Please note that the time of your appointment is intended to be the time your tests will begin. This is not the time you will see the physician. You may notice that other patients who have arrived after you will be called first. This occurs because they have been scheduled for special testing and do not need to be seen by the physician.
- Make sure to eat unless instructed otherwise, before your appointment.
- Only one family member or helper per patient will be admitted to testing area due to limitation of space.
- Bring your own snacks due to possible lengthy wait time.

Your patience and understanding is greatly appreciated. We hope to make your visit as brief and pleasant as possible. If you have any questions, please feel free to contact any one of our staff.

Victor H. Gonzalez M.D.

Privacy Policy

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be disclosed to other healthcare providers for the purpose of providing you with a continuum of quality healthcare.
- Your confidential healthcare information may be disclosed to your insurance provider for the purpose of receiving payment for providing you with healthcare services.
- Your confidential healthcare information may be disclosed to public officials or law enforcement agencies in an investigation in which you are a victim of abuse, crime, or domestic violence.
- Your confidential healthcare information may be disclosed to other healthcare professionals in the case of a healthcare emergency.
- Your confidential healthcare information may be disclosed to public health organizations or federal organizations in the matter of communicable diseases, defective devices, or a food or medication reaction.
- Your confidential healthcare information may NOT be disclosed for purposes other than those, which are outlined in this notice.
- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential healthcare information at any time.
- You may be contacted by office personnel to remind you of appointments, healthcare treatment options or other health services that may b of interest to you. Messages related to follow-up appointments may be left on an answering machine or with the individual answering the telephone.
- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved inyour healthcare or payment for health care services. However, the physician office may choose to refuse your restriction if it is in conflict of providing you with quality health care or in the event of a medical emergency.
- You have the right to receive confidential communication about your healthcare status.
- You have the right to review and request a copy of any and/or all portions of your healthcare information.
- You have the right to request changes be made to your healthcare information.
- You have the right to know who has obtained your confidential healthcare information and for what reason.
- You have the right to have a copy of this Privacy Notice upon request.
- The physician office is required by law to protect the privacy of its patients.
- The physician office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the Privacy Officer of this office and to the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to: ATTN: Privacy Officer, Valley Retina Institute, P.A., 1309 E. Ridge Rd., Ste 1, McAllen, TX 78503
- All complaints will be investigated. No personal issue will be raised for filing a complaint with the physician office.
- For further information about this Privacy Notice, please contact the Privacy Officer at (956) 631-8875.