Patrick Caskey, MD
Stephen Meffert, MD
Denise Kayser, MD, MPH
Thomas Schlesinger, MD, PhD
Shalini Yalamanchi, MD

Diseases and Surgery
of the
Macula, Retina and Vitreous

Dear ,

Welcome to our practice. We are very pleased to be able to participate in your care. As you know, your doctor has referred you to our office for a consultation.

Your appointment is scheduled with Dr.
On at

This packet includes a map, providing directions to our office, and some forms we ask that you complete prior to your appointment. **Please bring the completed forms with you to your appointment.**

- Patient Demographic Information (2-sided)
- Medical History (2-sides)

In addition to the forms listed above, please bring the following to your appointment:

1. A list of all current medications you are taking
2. All of your eye medications
3. Medical insurance cards
4. Photo identification with your name and picture on it

After obtaining copies of your insurance information, we will be happy to bill your insurance company for you. **If you do not have insurance or are unable to provide us with insurance information, payment is due in full at the time of service. Co-pays are due at the time of service.**

You will be receiving an extensive, comprehensive retinal consultation after which you may require diagnostic testing. **For this reason, we ask that you plan to spend about three hours at our office. In some cases we may need to perform treatment on the same day. This could extend your time in our office to over 3 hours.** In order to provide a comprehensive retinal consultation, your eyes will be dilated. After dilation, your vision will be blurry and be sensitive to sunlight for several hours. If you received diagnostic testing and treatment this will impair your vision even further. We recommend that you bring your sunglasses and have someone drive you to and from your appointment.

We request that you not wear any scented products. This includes perfume, cologne, and scented lotions.

We look forward to meeting you. Please feel free to contact our office at (707) 575-5353 should you have any questions prior to your appointment.

Sincerely,

Front Office Staff

North Bay Vitreoretinal Consultants, Inc.
3536 Mendocino Avenue, Suite 380
Santa Rosa, CA 95403
Tel (707) 575-5353 Fax (707) 523-7729
www.nbvcsr.com
update 09/08/2014 aa

Patrick Caskey, MD **Thomas Schlesinger, MD, PhD**
Stephen Meffert, MD **Shalini Yalamanchi, MD**
Denise Kayser, MD MPH

OFFICE POLICIES/FINANCIAL GUARANTEE

Keep For Your Records

In order to better serve you we would like you to review our office policies:

- We will bill up to three insurance companies for you, but require all appropriate information. Please provide copies of your current insurance card(s), claims address, all policy ID #'s, and subscriber information.

- Insurance companies have a claim filing time limit. If you do not provide accurate information in a timely fashion and we are unable to bill your insurance, ***all charges will be your responsibility***. If you have insurance and do not provide the billing information, you will be considered private pay and all charges will be your responsibility. If you elect to withhold insurance information, all retroactive billing will be your responsibility.

- Some insurance companies require prior authorization prior to your appointment. Please make sure that you provide our office with a copy of your authorization *prior to being seen*.

- Insurance co-payments and deductibles are always due at the time of service.

- **If you are private pay and have no insurance, payment is due in full at the time of service.**

- Should your account balance become delinquent, the balance may be referred to our collection agency: Fidelity Creditor Services located in Glendale, CA

- There is a $100 charge for missed appointments. **This fee is your responsibility and will not be billed to insurance companies.** To avoid this charge, we must receive notification at least 24 hours prior to a scheduled appointment. In addition, patients who have three "no-show" appointments will be automatically discharged from our practice.

- Medical records and completion of forms: Please allow 2 weeks for processing. All medical record requests will require an authorization from the patient **before** processing can take place. If medical records are not going directly to a physician, there will be a charge to the requesting party.

- The office's HIPAA Privacy Notice is available for viewing in the office, on our website, and a copy is available upon request.

- The office's Patient Right and Responsibility is available for viewing in the office and a copy was provided to you at the time you provided your account/billing information.

We are more than happy to discuss any of these issues with you in more detail if you require more information. These policies are subject to change.

Revised 09/08/14 aa

North Bay Vitreoretinal Consultants, Inc.
Patient Rights and Responsibilities

NBVC observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, personal values or belief systems.

You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the clinic.
- Receive assistance when requesting a change in primary or specialty physicians if other qualified physicians are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, in terms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care in the clinic, including medical records and, except as required by law, the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the clinic's policy regarding advance directives/living will. Expect the clinic to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the center's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Expect the clinic to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed

You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the clinic.
- Identifying any patient safety concerns.
- Observing prescribed rules of the clinic during your stay and treatment.
- Providing a responsible adult to transport you home from the clinic.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the clinic.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the clinic, including charges not covered by insurance.
- Payment to clinic for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.
- Immediately notifying our office if your condition is related to a worker's compensation injury, motor vehicle accident or assault.

You may contact the following entities to express any concerns, complaints or grievances you may have:

CENTER	Kelly Mulvey, Office Manager 707-523-7726
STATE AGENCY	ATTN: KATHLEEN J. BILLINGSLEY, RN DEPUTY DIRECTOR CALIFORNIA DEPARTMENT OF PUBLIC HEALTH CENTER FOR HEALTH CARE QUALITY (CHCQ) LICENSING AND CERTIFICATION DIVISION P.O. BOX 997377 MS 3000 SACRAMENTO, CA 95899 COMPLAINTS (800) 236-9747 GENERAL INFORMATION (916) 558-1784
MEDICARE	OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN: www.cms.hhs.gov/center/ombudsman.asp

PATIENT INFORMATION **Acct #** **DATE:**

First Name:	**MI:**	**Last Name:**	
Social Security #		**Driver's License #**	
Date of Birth:	**Age:**	**Sex:**	
Physical Address:		**City, State, Zip:**	
Mailing Address:		**City, State, Zip:**	
Marital Status:	**Name of Spouse/Partner:**		
Ethnicity:	**□ Decline to answer**	**Race:**	**□ Decline to answer**
Language:			
Home Phone:	**Work Phone:**	**Cell Phone:**	
Email:	**Preferred Contact Method: Home Work Cell**		
Who referred you to our practice?			
Ophthalmologist / Optometrist:		**City:**	
Primary Care Physician:		**City:**	
Employment Status: Retired Full time Part time Not employed			
Employer Name:			
Employer Address:		**Phone:**	
Student Status: Not a student Full time Part time			

EMERGENCY CONTACT INFORMATION

First Name:	**MI:**	**Last Name:**
Relationship:	**Male / Female**	
Home Phone:	**Work Phone:**	**Cell Phone:**

RESPONSIBILITY PARTY INFORMATION
(Person financially responsible. Parent if patient is a minor)

Who is financially responsible for payment after insurance or if no insurance? Patient Other (see below)		
If other, please give name, date of birth, relationship and complete the Responsible Party Form.		
First Name:	**MI:**	**Last Name:**
Date of Birth:	**Relationship:**	

PATIENT INFORMATION **Acct #** **DATE:**

First Name:	**MI:**	**Last Name:**

INSURANCE INFORMATION

Primary Insurance:	**ID#**	**Group Name:**	
Subscriber Name:	**Date of Birth:**	**Relationship:**	**M / F**
Secondary Insurance:	**ID#**	**Group Name:**	
Subscriber Name:	**Date of Birth:**	**Relationship:**	**M / F**
Tertiary Insurance:	**ID#**	**Group Name:**	
Subscriber Name:	**Date of Birth:**	**Relationship:**	**M / F**

_____ **(Initials of responsible party)** I request that payment of authorized Medicare (primary or secondary) &/or private insurance benefits be made on my behalf to my physician(s) at NBVC Inc., for services furnished to me. I authorize any holder of medical or other information about me to be released to the Centers for Medicare and Medicaid Services &/or my private insurance, and its agents, any information needed to determine these benefits for related services.

_____ **(Initials of responsible party)** I acknowledge I have received and understand the "Office Policy and Financial Guarantee" and "Patient Right and Responsibility" forms.

_____ **(Initials of responsible party)** The office's HIPAA Privacy Notice is available for viewing in the office, on our web site, and a copy is available upon request.

Please list the first and last name of friends or family whom you authorize us to share you private information. This information could include: billing, medical records, and/or your medical condition **Please do not list physicians**

1) **2)** **3)**

I hereby certify that the information listed above is correct to the best of my knowledge

Printed Name:	**Signature:**
Representative's first and last name:	**Representative's signature:**
Representative's address and phone number:	**Representative's relationship to patient:**

PATIENT NAME: **DATE OF BIRTH:** **Acct #**

FAMILY HISTORY: Are there any members of your family with the following diseases? YES NO If YES, please indicate.

Macular degeneration: Mother Father Sibling Grandparent
Retinal disorders: Mother Father Sibling Grandparent
Glaucoma: Mother Father Sibling Grandparent
Other: _____

High blood pressure: Mother Father Sibling Grandparent
Heart disease: Mother Father Sibling Grandparent
Diabetes: Mother Father Sibling Grandparent
Other: _____

SOCIAL HISTORY: ***OFFICE USE ONLY - TOBACCO BROCHURE PROVIDED ☐ DECLINED ☐ ***

Do you use tobacco? YES NO Type: _____
Years: _____ Amount daily?_____

Do you drink alcohol? YES NO 1-2 drinks 3-4 drinks 4 +
Frequency: Daily Weekly Occasionally Socially

OCULAR / EYE HISTORY: List any current or past eye conditions and treatments

Condition/Diagnosis	Treatment/Surgery	Eye	Date

OTHER ILLNESS/SURGERY: List any current or past conditions and surgeries

Condition/Diagnosis	Treatment/Surgery	Date

Received a pneumonia vaccination? YES (Year:_____) NO
Received a flu vaccine? YES (Mo._____Year_____) NO
Do you have an Advance Healthcare Directive? YES NO (If yes, please provide a copy)
Is your visit here related to a motor vehicle accident? YES NO
Is your visit here related to work injury? YES NO

GENERAL			GENITOURINARY			GASTROINTESTINAL		
Fever:	Yes	No	Blood in Urine:	Yes	No	Ulcers:	Yes	No
Weight loss:	Yes	No	Kidney Stones:	Yes	No	Acid reflux:	Yes	No
Cancer:	Yes	No	Urinary Infections:	Yes	No	Hiatal Hernia:	Yes	No
HEMATOLOGIC/LYMPHATIC			**RESPIRATORY**			**MUSCULOSKELETAL**		
Anemia:	Yes	No	Chronic bronchitis:	Yes	No	Arthritis:	Yes	No
Infection:	Yes	No	Asthma:	Yes	No	**INTEGUMENTARY**		
Bleeding disorder:	Yes	No	COPD:	Yes	No	Dermatitis:	Yes	No
Clotting disorder:	Yes	No	Sleep apnea:	Yes	No	Staph infection:	Yes	No
ENT	Yes	No	**NEUROLOGICAL**			**ENDOCRINE**		
Dizziness:	Yes	No	Alzheimer's:	Yes	No	Thyroid:	Yes	No
Sinus infection:	Yes	No	Stroke:	Yes	No	Diabetes:	Yes	No
Hearing loss:	Yes	No	MS:	Yes	No	If yes how long? _____		
CARDIOVASCULAR			**ALLERGIC/IMMUNOLOGIC**			Insulin dependent?	Yes	No
Heart attack/angina:	Yes	No	Seasonal allergies:	Yes	No	Circle one Type I Type II		
High blood pressure:	Yes	No	Rheumatoid Arthritis	Yes	No			
Circulation problems:	Yes	No	Lupus	Yes	No	**OTHER**		
Cholesterol treatment:	Yes	No	**PSYCHIATRIC**			History of HIV+	Yes	No
Pacemaker:	Yes	No	Depression, anxiety:	Yes	No	Tuberculosis	Yes	No
Cardiac stent placement:	Yes	No				Hepatitis: A B C	Yes	No

Please give details about anything not listed above or items circled YES

Date: _____

PATIENT NAME: **DATE OF BIRTH:** **Acct #**

LIST ALL ALLERGIES TO MEDICATIONS

_____

_____

_____

EYE MEDICATIONS (Include all prescription and over-the-counter medications)

MEDICATION	DOSE & EYE	TIME AND/OR FREQUENCY TAKEN	HOW IS MEDICATION TAKEN (drop, oral, ointment)

MEDICATIONS (Include all prescription and over-the-counter medications)

MEDICATION	DOSE	TIME AND/OR FREQUENCY TAKEN	HOW IS MEDICATION TAKEN (oral, injection, inhaled)

_____

Physician Signature Date