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Thomas Schlesinger, MD, PhD
Shalini Yalamanchi, MD
Matthew Powers, MD MBA
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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-pages)
- Medical History (2-pages)

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

1. A list of all current medications you are taking, prescription and over-the-counter
2. All of your eye medications
3. Medical insurance cards and photo identification

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.

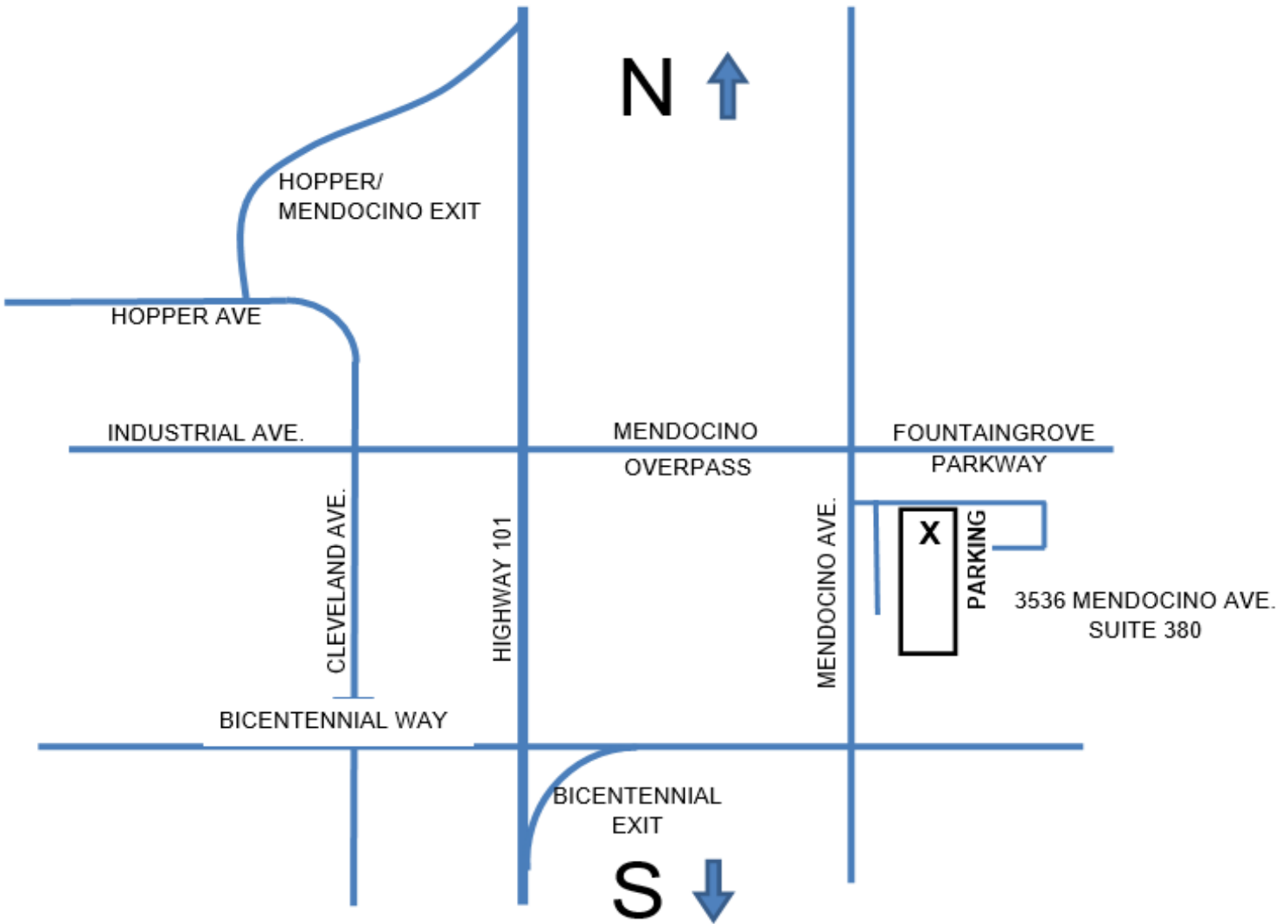
We look forward to meeting you. Please feel free to contact our office at (707) 575-5353 should you have any questions prior to your appointment. We require 24-hours notice if canceling or rescheduling.

Sincerely,

Front Office Staff
North Bay Vitreoretinal Consultants, Inc.
3536 Mendocino Avenue, Suite 380
Santa Rosa, CA 95403
Tel (707) 575-5353 Toll Free 888-673-8462 Fax (707) 523-7729
www.nbvcsr.com

**NORTH BAY VITREORETINAL CONSULTANTS
3536 MENDOCINO AVE SUITE 380
707-575-5353**

Stephen Meffert, MD Thomas Schlesinger, MD PhD
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From the North:

Take 101 south to the Hopper / Mendocino exit. At the stoplight, Hopper Ave, turn left. Continue around the bend. At the first stoplight, Industrial Ave / Mendocino Overpass, turn left. This will take you over the freeway. At the first stoplight, Mendocino Ave, turn right. We are the second building on the left, next to Extended Stay America. Turn left into our driveway. Parking is located up the hill and around to the back of the building.

From the South:

Take 101 north to the first Bicentennial (east) exit. At the second stoplight, Mendocino Ave, take a left. We are on the right side of the road just before Fountaingrove Parkway. Turn right into our driveway. Parking is located up the hill and around to the back of the building.

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.
- It is your responsibility to confirm if we are in your insurance plan's provider network. We suggest you contact member services for your insurance before your appointment.
- 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. Please call your member services if you have questions regarding patient responsibility.
- **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 no-show appointments and same day canceled or rescheduled 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 do not comply may be dismissed 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.

Please let us know if you have any questions. These policies are subject to change.

North Bay Vitreoretinal Consultants, Inc.

Patient Rights and Responsibilities

****Keep for Your Records****

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
- at any time. Grievances may be lodged with the state agency directly using the contact information provided below.

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

Account #

Date: _____

PATIENT INFORMATION

First Name: MI: Last Name:

Preferred Name:

Social Security # Driver's License #

Mailing Address: City, State, Zip:

Physical Address: City, State, Zip:

Date of Birth: Age: Sex:

Marital Status: Name of Spouse/Partner:

Ethnicity: Decline to answer Race: Decline to answer Language:

Home Phone: Work Phone: Cell Phone:

Email: Preferred Phone Number: Home Work Cell

Who referred you to our practice?

Ophthalmologist / Optometrist: City:

Primary Care Physician: City:

Employment Status: Occupation:

Employer Name:

Employer Address: Phone:

Student Status:

EMERGENCY & HIPAA CONTACTS

1) Name: Authorized to receive medical/billing info? Yes No

Relationship: Male / Female

Home Phone: Cell Phone: Work Phone:

2) Name: Authorized to receive medical/billing info? Yes No

Relationship: Male / Female

Home Phone: Cell Phone: Work Phone:

3) Name: Authorized to receive medical/billing info? Yes No

Relationship: Male / Female

Home Phone: Cell Phone: Work Phone:

Empty form area for additional contact information.

		Date:
RESPONSIBLE 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 list below and complete Responsible Party Form		
First Name:	MI:	Last Name:
Date of Birth:	Relationship:	
INSURANCE INFORMATION		
Primary Insurance:	ID#	Employer Name:
Subscriber Name:	Date of Birth:	Relationship: M / F
Secondary Insurance:	ID#	Employer Name:
Subscriber Name:	Date of Birth:	Relationship: M / F
Tertiary Insurance:	ID#	Employer Name:
Subscriber Name:	Date of Birth:	Relationship: M / F
<p>_____ (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. I understand this assignment is in effect throughout the duration of my care at NBVC Inc.</p> <p>_____ (Initials of responsible party) I acknowledge I have received and understand the "Office Policy and Financial Guarantee" and "Patient Right and Responsibility" forms.</p> <p>_____ (Initials of responsible party) The office's HIPAA Privacy Notice and Patient Rights and Responsibilities are available for viewing in the office, on our website, and a copy is available upon request.</p>		
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:	

NAME:

DOB:

DATE:

VACCINATIONS	Have you had?		Month	Year
Flu (Influenza)	No	Yes		
Pneumonia	No	Yes		

If this visit is related to a **Motor Vehicle Accident** or **Work Related Injury**, alert the front desk and billing department *prior* to completing this form

EYE HISTORY	Do <u>you</u> have?		Or any immediate family have?		
Diabetic Retinopathy	Yes	No	Mother	Father	Sibling
Glaucoma	Yes	No	Mother	Father	Sibling
Macular Degeneration	Yes	No	Mother	Father	Sibling
OTHER: (list surgeries in "surgery" sections below)					

GENERAL HISTORY	Do <u>you</u> have?		Or any immediate family have?		
Arthritis	Yes	No	Mother	Father	Sibling
Cancer	Yes	No	Mother	Father	Sibling
Type(s):	If YES: Active or In Remission				
Diabetes: How long? _____	Yes	No	Mother	Father	Sibling
Type 1 or Type 2 (circle)	Last A1c:	Blood Sugar:			
Heart Disease	Yes	No	Mother	Father	Sibling
High Blood Pressure	Yes	No	Mother	Father	Sibling
High Cholesterol	Yes	No	Mother	Father	Sibling
Autoimmune (eg Lupus)	Yes	No	Mother	Father	Sibling
Stroke	Yes	No	Mother	Father	Sibling
HIV or Hepatitis C (circle)	Yes	No	If HIV, viral load: CD4 count:		
OTHER: (list surgeries in the "surgery" sections below)					

SMOKING STATUS:	Never Smoker	Former Smoker	Current, some day smoker
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****OFFICE USE****
Tobacco Brochure
Provided (circle)

EYE SURGERIES	Have you had?		Which Eye?			Year
Cataract Surgery	Yes	No	Right	Left	Both	
Retina Surgery	Yes	No	Right	Left	Both	

OTHER EYE SURGERIES: (list which eye and approximate years)

NAME:

DOB:

DATE:

OTHER MAJOR SURGERIES: (list with approximate years)

EYE MEDICATIONS: (eye drops, tablets)

No Eye Medications (circle)

NAME (or color top)

HOW MANY TIMES A DAY?

WHICH EYE? (Right, Left, Both)

OTHER MEDICATIONS: (name / dose) (Include Supplements)

No Medications (circle)

NAME

DOSE

NAME

DOSE

Ongoing cancer treatment?

Yes No

Type of cancer:

Ever been on **Plaquenil**?

Yes No

Start Date: Dose:

Do you take blood thinners?

Yes No

Ever been on **Elmiron** (pentosan)?

Yes No

ALLERGIES: (list with reaction)

No Drug Allergies (circle)

NAME

REACTION

NAME

REACTION

Any additional information you would like your physician to know? (use back of form)