nera New England Retina Associates
Specializing in diseases and surgery of the retina and vitreous

David Tom, MD, FACS
Gregory Haffner, MD
John Huang, MD, MBA, CPE
Erol Verter, MD

2200 Whitney Avenue, Suite 300 Hamden, CT 06518
Phone: (203) 288-2020 • Fax: (203) 288-2470

Welcome to our practice!

Attached please find your new patient paperwork which is to be completed **PRIOR** to your visit with us. **Please bring this completed paperwork** including physician's phone numbers and addresses along with your insurance cards, co-pay and any referral your insurance company may require. We would also appreciate your bringing the doctor a copy of your current medications. Also enclosed in this welcome packet are directions to all of our offices with a list of directions and instructions.

Please expect your first visit with the doctor to be at least 2-3 hours.

We look forward to meeting you.

Sincerely yours,

David Tom, M.D.
Gregory Haffner, M.D.
John Huang, M.D.
Erol Verter, M.D.

1445 East Putnam Avenue
Old Greenwich, CT 06870
Phone: (203) 698-8880
Fax: 203-698-9178

999 Silver Lane, Unit 2B
Trumbull, CT 06611
Phone: (203) 445-9320
Fax: (203) 242-8661

162 Kings Highway North
Westport, CT 06880
Phone: (203) 222-7474
Fax (203) 221-1591

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PATIENT INFORMATION

**DATE _____ SEX _____MALE_____FEMALE

_____ DOB ____/____/_____

PATIENT NAME

_____ AGE _____ _____

ADDRESS

_____ **Social Security Number**

CITY, STATE ZIP CODE _____

( ) _____ ( ) _____

HOME PHONE CELL PHONE

( ) _____

WORK PHONE CONTACT PERSON:

Email Address: _____

**PHARMACY

( )

NAME ADDRESS PHONE

**PRIMARY CARE PHYSICIAN

**( )

NAME ADDRESS PHONE

**REFERRING DOCTOR

**( )

NAME ADDRESS PHONE

INSURANCE

**PRIMARY INSURANCE **ID# **SUBSCRIBER NAME **DOB

SECONDARY INSURANCE ID# SUBSCRIBER NAME DOB

Please complete the following information:

Race: Asian Hispanic White Black/African American Other

Ethnicity: **Hispanic/Latino** **Non Hispanic/Latino** **Refused to Report**

Language spoken: _____

EMERGENCY CONTACT FORM

PATIENT'S NAME:_____ DOB:_____

EMERGENCY CONTACT NAME:_____

EMERGENCY CONTACT PHONE NUMBER:_____

RELATIONSHIP TO PATIENT:_____

****

EMPLOYEE USE ONLY:

PLEASE OBTAIN EMERGENCY CONTACT INFORMATION AT TIME OF PATIENT'S VISIT AND ENTER INTO MDI.

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PATIENT INFORMATION SHEET

Name: _____ **Date:** ____/____/____

Date of Birth: _____/_____/_____

Purpose of your visit : _____

List all Allergies to Medications: _____

1)	Are you allergic to LATEX?	YES NO
2)	Do you have macular degeneration?	YES NO
3)	Do you have glaucoma?	YES NO
4)	Do you have cataracts?	YES NO
5)	Have you ever had eye surgery?	YES NO
6)	Have you ever had an eye injury?	YES NO
7)	Have you ever had temporary loss of vision?	YES NO
8)	Have you ever had a lazy eye?	YES NO
9)	Do you have diabetes?	YES NO
10)	Have you even been diagnosed with high blood Pressure?	YES NO
11)	Do you have ANY heart trouble?	YES NO
12)	Have you ever been diagnosed with lung problems?	YES NO
13)	Have you ever had a stroke?	YES NO
14)	Have you ever had stomach or intestional problems?	YES NO
15)	Have you ever had urinary tract problems?	YES NO
16)	Have you ever been diagnosed with cancer?	YES NO
17)	Have you ever been diagnosed with thyroid disease?	YES NO
18)	Do you have ANY bleeding disorders/problems?	YES NO
19)	Do you have arthritis?	YES NO
20)	Are you on any blood thinning medication?	YES NO
21)	Have you ever had treatment for psychiatric disorders?	YES NO
22)	Have you ever used IV drugs?	YES NO
23)	Have you had any recent weight loss or gain?	YES NO
24)	Have you had any recent fevers?	YES NO
25)	Do you have any skin conditions?	YES NO
26)	Do you have any systemic infections?	YES NO

27) Do you have problems with your ears, nose or throat? YES NO

28) Do you have mouth sores or problems swallowing? YES NO

29) Have you been hospitalized within the past 5 years? YES NO

List surgeries and dates:

_____

_____

_____

What is your current occupation? _____

If you smoke or have ever smoked, answer the following:
# of packs per day _____ **# of years smoked** _____ **Year you stopped smoking?** _____

Have you traveled in the last 6 months? If yes, where? _____

List all current medications and doses (unless you provide a copy of your list):

Medication Name	Dosage	Taken how often? PRN=when needed	Route	Reason
		___ times per day __ PRN	_oral _topical _injection	
		___ times per day __ PRN	_oral _topical _injection	
		___ times per day __ PRN	_oral _topical _injection	

Continue on back if necessary...

Do you have a FAMILY history of:

1) Diabetes YES NO
2) Retinal Detachment YES NO
3) Glaucoma YES NO
4) Macular Degeneration YES NO
5) Rheumatoid Arthritis YES NO
6) Cancer YES NO
7) High Blood Pressure YES NO
8) Other (Please explain)

_____

PATIENT SIGNATURE: _____

DATE: _____/_____/_____

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HIPAA WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of New England Retina Associates, P.C. I hereby acknowledge receipt of New England Retina Associates, P.C.'s notices of Privacy Practice.

Name: (Please Print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____(patient's name). I hereby acknowledge receipt of New England Retina Associates, P.C's Notice of Privacy Practices with respect to the patient.

Name: (Please Print):

_____

Relationship to Patient: _____Parent _____ Legal Guardian

Signature of Parent/Legal Guardian: _____

Date: _____

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HIPAA PATIENT COMMUNICATION FORM

Family and Friends:

It is the policy of New England Retina Associates, P.C. not to release confidential medical information regarding your treatment without your authorization except for a) parent/legal guardian, other persons authorized by (you, the patient) or b) as we may reasonably infer from the circumstances – for example, if you bring a family or friend in to the exam room, we will assume, unless you object that the person is entitled to receive information regarding your treatment, c) in emergency situations or d) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1995 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friend, significant other, or caretakers, please indicate that below so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment care: (If you wish to add names later on, please confirm this in writing, or call our staff)

Spouse: _____ Yes _____ No _____

Parent: _____ Yes_____ No _____

Other: _____Yes_____ No _____

_____ Yes_____ No _____

ALTERNATIVE COMMUMICATIONS: You are also entitled to specify alternative, reasonable means of communication.

I hereby request the following means of contact only:

_____

Patient Name: _____

Signature of Patient: _____

Date: _____

Office use only.....Changes authorized by patient over the phone:

_____

Date: _____

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Beneficiary: _____

1) **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to New England Retina Associates, for services furnished me by New England Retina Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medication information necessary to pay the claim. If another health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved my signature authorizes releasing the information to the insurer or agency shown. New England Retina Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

2) **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 100 form or on other approved claim forms; my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to New England Retina Associates.

3) **RELEASE OF INFORMATION:** New England Retina Associates may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable or under contract to New England Retina Associates for reimbursement for services rendered, and (2) any healthcare provider for conti8nued patient care. New England Retina Associates may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State and Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4) **OTHER INSURANCES:** I understand that New England Retina Associates contracts with specific health care service plans and that I am responsible to know if they are considered contracted providers by my insurance plan. I agree that I am individually to pay the full charges of all services rendered to me by New England Retina Associates if I belong to a plan that does not contract with them.

5) **NON-CONTRACTED SERVICES:** I understand that New England Retina Associates contract with healthcare service plans (i.e. HMO's, PPO's) related only to items and services which are "covered" by the healthcare plans. Accordingly, I accept full financial responsibility for all items or services which are determined by the healthcare service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with the healthcare plan or in the benefit summary plan the healthcare service plan furnishes to the patient and the treatment or tests not authorized by the healthcare plan. The undersigned agrees to cooperate with New England Retina Associates to obtain necessary healthcare plan authorizations.

6) **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by New England Retina Associates, I will pay my account at the time the service is rendered or will make financial arrangements satisfactory to them for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to New England Retina Associates. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to New England Retina Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Signature _____ **Date:** _____

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Insurance Coverage Information for our patients

It is extremely important that you are aware of your insurance coverage. There are many insurance plans with which we participate. However, many of these plans have variations, as well as multiple rules and regulations. These must be followed if you want your insurance plan to cover (pay for) services.

Be aware of what is covered in your plan. Not all services are covered. The patient is responsible for any services not covered. You will be billed accordingly.

Any and all copays/deductibles are due at the time of the office visit. We are required by the insurance company to collect the copayment.

Be aware if an insurance referral is needed from your primary care physician and how it should be obtained prior to your visit.

Know if any pre-certification or approval is required from your insurance company for any lab work or procedure ordered by any one of our doctors.

Know whether or not there is a specific laboratory where your lab work needs to be done. If this is the case with your insurance company, and you do not inform our office, you the patient, are responsible for the charges incurred.

Know if there is a particular pharmacy from which you obtain your medications.

We will make every effort to help you with the above, but cannot guarantee that we will know every rule and regulation. Your cooperation is needed in order for us to serve your healthcare needs and ensure that you receive any and all insurance coverage to which you are entitled.