Patel Retina Institute

Patient Name:____ Date of Birth:_________________________

***Consent for Examination*:**

I hearby consent to such examination procedures that may be necessary while I am a patient of Patel Retina Institute. I recognize that my treatment and care could be observed and in some instances, aided by physicians and/or technicians under supervision.

Patient Signature:____ **Date**:________________________________

To Release Medical Information and to Pay Insurance benefits:

I request that payment of authorized insurance benefits be made either to me or on my behalf to Patel Retina Retina Institute or any physician employed by any of the entities for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and its agents or any private insurance company, any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible to obtain any referrals if my insurance plan requires this. I am liable for the cost of my services rendered if I fail to obtain a referral.

I further agree to pay all charges connected with this treatment not covered by insurance I may have, and understand that insurance coverage does not release me from obligation to begin payment within 30 days of treatment. Copies of this agreement shall be as valid as the original signature on file with Patel Retina Institute.

Patient Signature:____ **Date**:_______________________________

Information Regarding Dilating Drops:

Dilating drops are used to dilate or enlarge the pupils of the eye allowing the physician to get a better view of the inside of your eye. Dilating drops frequently blur your vision for a length of time which varies from person to person. Bright lights will become bothersome. It is not possible for your physician to predict how much your vision will be affected. Driving may be difficult immediately after your exam. It is best if you make arrangements to have a driver accomy you to your appointment.

Adverse reaction, such as angle-closure glaucoma, may be triggered from dilating drops. This is extremely rare but treatable.

I hearby authorize Patel Retina Institute and/or any other physician/assistant be designated by him/her to administer dilating drops. The eye drops are necessary to diagnose my condition.

Patient Signature:____ **Date**:______________________________

Patel Retina Institute

Patient Name:____ Date: _____________________________

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _________________________________, hereby give my consent to Patel Retina Institute to use or disclose for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________________.

I acknowledge receipt of Patel Retina Institute's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how Patel Retina Institute may use and disclose my confidential information.

I understand that Patel Retina Institute has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any revised notices will be provided to me or made available at my next office visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Patel Retina Institute.

Patient Signature:____ **Date**:____________________________

If you are not the patient, please specify your relationship to the patient:____________________________

Patel Retina Institute

Patient Name:____Date:_________________________________

These questions are being asked because of new federal guidelines enacted into law under The American Recovery and Re-Investment (ARRA) HITECH Act. Please note, options listed for race/ethnicity and language were devised by the United States Government, not Patel Retina Institute.

Marital Status:

_____Single _____Married _____Life Partner _____Divorced _____Widowed

Race:

____White

____Black/African American

____American Indian/Alaska Native

____Asian

____Native Hawaiian/Pacific Islander

____Unavailable/Unknown

____Declined to Specify

Ethnicity:

____Hispanic/Latino

____Not Hispanic/Latino

____Unavailable/Unknown

____Declined to Specify

Preferred Language: ____

I authorize Patel Retina Institute to speak to the following people regarding my medical information:

Name:_________________________________ Phone number:____________________ Relationship:____________

Name:_________________________________ Phone number:____________________ Relationship:____________

Name:_________________________________ Phone number:____________________ Relationship:____________

Patient Signature:____ **Date**:____________________________