HUDSON RETINA

Howard J. Kaplan, M.D.
Nancy E. Miller-Rivero, M.D.

Patient Information

Patient's Name: _____
Last First Middle Initial

Date of Birth: ____/____/____ Gender: ____Male ____Female

Address: _____City_____State_____Zip_____

Phone: _____Email: _____

Social Security Number*: ____-____-____
*If referral from VA, SSN is required

Occupation: _____ Employer: _____

Name of Parent/Legal Guardian or Legal Representative: _____

Emergency Contact: _____
Name Relationship to Patient Phone Number

Referred By: _____
Name Address Phone

Primary Care Physician: _____
Name Address Phone

Pharmacy: _____
Name Address Phone

Is this a Worker's Compensation Case? _____ Yes _____ No
Is this a No Fault Case? _____ Yes _____ No

Assignment of Benefits

I hereby assign all medical and/or surgical benefits,to include major medical benefits to which I am entitled to including Medicare, HMO, private insurance and any other health plans:
HUDSON RETINA: HOWARD J. KAPLAN, MD, PC, AND NANCY MILLER-RIVERO, MD.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. This information includes history obtained, physical findings, diagnosis and prognosis.

Patient Signature: _____Date: _____

94 Pine Street • Poughkeepsie, NY 12601
Phone: (845) 454-3030 • Fax: (845) 454-4125

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Patient Medical History

Medical History:

- ☐ Heart/Circulatory Problems
- ☐ High Blood Pressure
- ☐ Diabetes
  - ☐ **Type 1**
  - ☐ **Type 2**
- ☐ High Cholesterol
- Thyroid Disease **(Graves, Hypo, Hyper)**
- ☐ Respiratory Problems **(Asthma, COPD)**
- ☐ Immunological **(Lupus, Sarcoidosis)**
- ☐ Stroke
- ☐ Neurological **(MS, Epilepsy, Dementia)**
- ☐ Cancer: _____

Family History

- ☐ Unknown
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Other: _____

Ocular History

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment/Tear
- ☐ Macular Degeneration
- ☐ Loss of Vision
- ☐ Distortion of Vision
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Shadow/Curtain
- ☐ Trauma (Date:_____)
- ☐ Other Ocular History: _____

Eye Surgeries/Procedures:

Cataract Surgery: _____

Retina: _____

Other: _____

Current Eye Drops/Medications:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

_____

Major Surgeries:

_____

_____

_____

Allergies to Medications:

_____

_____

_____

☐ No Known Drug Allergies

Social History:

- ☐ Current Every Day Smoker
- ☐ Former Smoker
- ☐ Alcohol
- ☐ Recreational Drugs/Street Drugs

Patient Name: _____ Date: _____

Patient/Representative Signature: _____

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PATIENT HIPAA AWARENESS

With my permission, Howard J. Kaplan, M.D, P.C or Nancy Miller-Rivero, M.D may use and disclose protected health information (PHI) about me to carry out treatment, payments and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Howard J. Kaplan or Dr. Nancy Miller-Rivero reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Howard J. Kaplan or Dr. Nancy Miller-Rivero may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or anything pertaining to my clinical care.

With my permission, the office of Dr. Howard J. Kaplan or Dr. Nancy Miller-Rivero may E-mail to myself or other designated entities any items that assist the practice in carrying out TPO. I have the right to request that Dr. Howard J. Kaplan or Dr. Nancy Miller-Rivero restrict how it uses or discloses my PHI to carry out my TPO. However, the practice in not required to agree to my requested restrictions but, if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Howard J. Kaplan or Dr. Nancy Miller-Rivero to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent.

_____

Patient's Name (Please print)

_____ _____

Patient or Legal Guardian Signature Date

I authorize the release of information regarding my records, services, treatment and care to the following individuals:

_____ _____

Name of Person Relationship

_____ _____

Name of Person Relationship

_____ _____

Name of Person Relationship

FINANCIAL WAIVER FORM

To our patients:

This practice participates with many different insurance companies and their various plans. We try to keep up with the terms of each but, this is not always possible. If you should be a member of a Managed Care Plan, you should be aware that most of these plans require you Primary Care Provider to provide prior referral authorization for specialist visits. It is your responsibility to obtain preauthorization. **If no authorization has been obtained prior to you being seen, your insurance will not cover the charges for the visit and you will be responsible for them.**

Even if authorization is obtained, a Managed Care Plan has the ability to deny payment at a later date, claiming that the procedure is non-covered or not medically necessary. Any insurance plan may deny payment after telling us that it should be covered. This might be because of an error, an exclusion in the policy or because of a change in your policy between the time your authorization was confirmed and the time it was carried out. It is also possible for them to determine that your coverage is no longer valid on the date that the visit took place. **Should any of these unforeseen occurrences take place, you will become responsible for the charges involved regardless of what we may have estimated your responsibility to be.**

I have read the above statements and understand them and my responsibilities with respect to membership in a Managed Care Program, if applicable.

I understand my financial responsibilities in respect to paying all charges not covered by my insurance for any reason (not to exceed the allowable fee, as determined by my insurance company).

I waive my rights to insurance benefits if I have not accurately informed you of my insurance coverage prior to my treatment.

_____

Patient/Legal Representative Name

_____

Patient/Legal Representative Signature

_____

Date

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