Ozark Retina & Macula

Springfield, MO 65804

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of information:** I authorize the disclosure of any or all of the information in my medical record to:
   a. Any person, corporation, or agency responsible for all or part of Ozark Retina & Macula services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to Ozark Retina & Macula treatment of services.
   b. This includes, but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
   c. I further authorize Ozark Retina & Macula at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.
2. **Assignment of Benefits:** I assign to Ozark Retina & Macula the benefits due me covering Ozark Retina & Macula services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
3. **Medicare Patients:** I authorize Ozark Retina & Macula to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.
4. **Financial Obligation for Ozark Retina & Macula:** I agree that I am financially responsible for payment of all amounts for services provided by the office and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Ozark Retina & Macula and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.
5. **Guarantor's Responsibility:** I have read and understand the financial obligation above and agree to the terms as stated.

CONSENT FOR TREATMENT: As a patient of Ozark Retina & Macula, I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and/or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary.

AUTHORIZATION FOR DISCLOSURE: I give permission to discuss with the individual(s) I have listed:
Please check appropriate box (es)

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

I understand that I am responsible for notifying this office, in writing, or any changes to this authorization to disclose my personal health information.

Name _____ Relationship _____ Phone# _____
Name _____ Relationship _____ Phone# _____
Name _____ Relationship _____ Phone# _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of Ozark Retina & Macula sets forth the ways in which my personal health information may be used or disclosed and outlines my rights with respect to such information. I acknowledge that on _____/_____/_____,

□ I received a copy of the Ozark Retina & Macula Notice of Privacy Practices
□ I declined a copy of the Ozark Retina & Macula Notice of Privacy Practices

Patient Name (print) _____ Signature _____
(Patient or legal representative) Date

Patient Date of Birth or SSN _____Relationship if signed by other: _____

Date _____/_____/______

Ozark Retina & Macula

Acct# __________

HEALTH AND MEDICATIONS INFORMATION

Patient Name: ____ Date of Birth _______/_______/__________

Employment status (circle) Unemployed / Student / PT / Full Time / Retired **Marital Status** (circle) Single/Married/Divorced

Eye Doctor **First and Last Name**____ Phone (_____)___________________

Address ____

Primary Care **First and Last Name** ______________________________________ Phone (_____)___________________

Address ____

Referring Physician **First and Last Name** ________________________________ Phone (_____)___________________

Address ____

Pharmacy Name & Address: ____ Phone (_____)___________________

Please circle any disease or medical condition you currently have or have had in the past.

Eye Surgery or Disease: List _____________________________

____

____

Pacemaker, Defibrillator, Oxygen Use, Heart Disease
High Blood Pressure, High Cholesterol, Diabetes Type 1,
Diabetes Type 2 Year diagnosed ___________________
Thyroid Disease, Enlarged Prostate, Kidney Disease, Asthma,
Emphysema, Bronchitis, COPD, Sleep Apnea,
Difficulty Breathing, Difficulty Lying Flat, Stomach Ulcers,
Acid Reflux, Crohn's Disease, Diverticulitis, Liver Disease,
Lymph Disease, Hepatitis, HIV, AIDS, Immunologic Disease,
Seasonal or Food Allergies, Hard of Hearing,
Headaches, Stroke, Seizures, Migraines,
Muscle Disease, Osteoarthritis, Rheumatoid Arthritis, Lupus
Cancer: Type: ____________________Radiation or Chemo?
Psychiatric or Mental Disorder: Dementia, Alzheimer's,

Have you received a flu shot? Y / N When? _________________
Have you received a pneumonia shot? Y / N When? __________
Are you a fall risk? Y /N

Social History – Do you:
Smoke, Use Tobacco How Much? ___________________________
Former Smoker? Yes / No
Drink Alcohol: Frequency: ________________________________
Sexually Transmitted Disease, Drug Abuse

Family History: Does anyone in your family have: (Circle)
Kidney Disease, Arthritis
Glaucoma, Macular Degeneration, Retinitis Pigmentosa, Diabetes,
Hypertension, Thyroid Disease, Cancer, Heart Disease

Please List Any Surgeries and the Date

__________________________________**Date:** ________________
__________________________________**Date:** ________________
__________________________________**Date:** ________________
__________________________________**Date:** ________________

List any drug allergies & reactions to those drugs:

____
____
____

What eye drops are you taking?

____
____
____

Any adverse reaction to general anesthesia? Yes / No
Explain ______________________________________

____

List ALL medications, drugs and vitamins

Name of Drug	**Mg**	**Dosage**