HARBOR RETINA CENTER

Deepak Mangla, MD
Vitreoretinal Diseases and Surgery
Office: 810-356-9700
Fax: 810-356-9700

Harbor Retina Center
3273 Davison Rd., Suite 1
Lapeer, MI 48446
www.harborretina.com

Dear Patient,

You have a retinal consultation with Dr. Deepak Mangla

On_____ at _____.

We would like to take this opportunity to welcome you to our practice. Please complete all enclosed forms and bring them with you to your appointment along with your medical insurance card and driver's license and a list of your current medications. Harbor Retina Center does not bill vision insurance plans.

Your initial appointment is a complete evaluation and consultation and may take up to 2 hours. Both of your eyes will be dilated. We ask that you please plan accordingly and request that you come with a driver.

If you have a managed care health insurance plan, please verify with your plan that the physician you are scheduled to see in our office is in the plan network; this will help you avoid “out of network” fees.

Please contact your primary care physician to initiate prior authorization for your appointment and testing in our office if your plan requires prior authorization. Remember, your health insurance plan is a contract between you and your insurance company. You are responsible for any deductibles, coinsurance and copayment amounts determined by the type of plan you have chosen. If you have a deductible and/or co-payment with your insurance plan, this payment is expected at the time of your visit. Private pay patients will be expected to pay $200 toward their consultation at check-in.

We understand that there may be circumstances and/or changes in your schedule that may prevent you from keeping your appointment. If this situation arises, we ask that you call us at least 24 hours in advance and we will gladly reschedule your appointment. Please be advised that if you miss your scheduled appointment, and do not call us to reschedule or cancel, you will be billed a $25.00 no show fee.

It is the responsibility of every Harbor Retina Center employee (physicians, administration, office staff, research staff, and technicians) to provide care to those suffering from vision threatening medical conditions in a healing and respectful manner. The Harbor Retina Center “family” is composed of people from all walks of life. Likewise, our medical practice provides care to people from all walks of life, regardless of socioeconomic status, religion, sexual orientation, or race. Just as we strive to treat you and every one of our patients with the utmost respect, we expect you to reciprocate the same courtesy towards our staff and our other patients.

Sincerely,

Deepak Mangla, M.D

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Legal First Name: _____ Legal Last Name:_____

Preferred Name:_____ Date of Birth :_____

Home Number: _____ Mobile Number:_____ OK for texts: ☐

Email:_____

Address:_____

City: _____ State:_____ Zip Code: _____

Gender : ☐ Male ☐ Female Social Security Number:_____

Marital Status :
- ☐ Single
- ☐ Married
- ☐ Divorced

Race:
- ☐ Native American/Alaskan
- ☐ Caucasian/White
- ☐ Spanish
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Asian
- ☐ Hispanic/Latino

Language Preference:
- ☐ English
- ☐ Other:

Contacts:

Emergency Contact and relation:_____Phone:_____
Family Doctor:_____ Phone:_____
Referring Doctor:_____ Phone:_____

Responsible Party: (If minor, guardian, or Power of Attorney)

Name:_____Phone: _____DOB:___/____/____
Address:_____
Relationship to patient:_____

Primary Insurance Information:

Name of Insurance:_____
Name of policyholder:_____
DOB:_____
ID#:_____
Relationship to patient:_____

Secondary Insurance Information:

Name of Insurance:_____
Name of policyholder:_____
DOB:_____
ID#:_____
Relationship to patient:_____

How Did You Hear About Us?

- ☐ Referring Provider
- ☐ Yelp
- ☐ Instagram
- ☐ Newspaper_____
- ☐ Friend/Family _____
- ☐ Facebook
- ☐ Google Search
- ☐ Other_____

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MARK ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

- ☐ Loss of Vision
- ☐ Distortion
- ☐ Blurred Vision
- ☐ New Floaters
- ☐ Eye Pain/Soreness
- ☐ Flashes of Light
- ☐ Other:_____

MARK ALL MEDICAL DIAGNOSES THAT APPLY TO YOU, BOTH PRESENTLY AND IN THE PAST-
(If there is more than one presentation of your diagnosis, please circle the one that applies)

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis- Osteo / Rheumatoid
- ☐ Arrhythmia (irregular heart beat)
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer:

Type:_____

- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes -Type I / Type II
- ☐ Emphysema
- ☐ GERD/Gastric Reflux
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lupus
- ☐ Migraines-Ocular/Classic
- ☐ Prostate Complications
- ☐ Thyroid- Hyper/Hypo
- ☐ Seizure Disorder
- ☐ Stroke

Other:_____

OCULAR HISTORY

- ☐ No Significant History
- ☐ Bell's Palsy
- ☐ Cataract
- ☐ Choroidal Nevus
- ☐ Choroidal Melanoma
- ☐ Diabetic Retinopathy
- ☐ Double Vision
- ☐ Dry Eye Syndrome
- ☐ Fuch's Dystrophy
- ☐ Glaucoma
- ☐ Herpes Simplex
- ☐ Iritis
- ☐ Lazy Eye(amblyopia)
- ☐ Macular Degeneration
- ☐ Macular Hole
- ☐ Macular Pucker
- ☐ Nerve Palsy
- ☐ Ocular Migraines
- ☐ Retinal Detachment
- ☐ Retinal Vein Occlusion
- ☐ Retinal ArteryOcclusion
- ☐ Retinal Tear
- ☐ Retinal Injections
- ☐ Retinal Laser

Other:_____

OCULAR SURGERIES

- ☐ Cataract Surgery
- ☐ Corneal Surgery
- ☐ Eyelid Surgery
- ☐ Eye Muscle Surgery
- ☐ Glaucoma Surgery
- ☐ Laser Surgery
- ☐ LASIK
- ☐ Retinal Surgery

Reason for surgery, date, and Surgeon :_____
Reason for surgery, date, and Surgeon :_____
Reason for surgery, date, and Surgeon :_____
Reason for surgery, date, and Surgeon :_____

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FAMILY HISTORY

- ☐ Blindness
- ☐ Cataract
- ☐ Cancer
- ☐ Diabetes
- ☐ Retinal detachment/tear
- ☐ Stroke
- ☐ Glaucoma
- ☐ High Blood pressure
- ☐ Macular degeneration
- ☐ Heart Attack

SMOKING HISTORY

☐ Smoker ☐ Former Smoker ☐ Never Smoker

Packs per day_____ Quit (year)_____

MEDICATIONS: List all current medications you are taking (including prescription, over-the-counter, herbals, vitamins, mineral supplements, dietary supplements) Attach a list if necessary.

Name	*Dose*	*Frequency*

ALLERGIES: Do you have any ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No

If YES, please list the medications and the reaction to them (including difficulty breathing, confusion, cough, dizziness, swelling of limbs, headache, lethargy, nausea, vomiting, rash, hives)

Medication	*Reaction*

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical and personal information that is provided to us. By law, we are required to maintain the privacy of medical information provided to us, provide notice of our legal duties and privacy practices, and abide by the terms of this notice.

Information collected about you: In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as your name, address, phone number, medical history, insurance information, and information regarding other medical providers. In addition, we will be collecting data about you during our examinations which will be contained within your medical record. Some information may also be provided to us by other individuals or organizations that are part of your circle of care, such as the referring physician, other doctors, your health insurance plan and close friends and family.

How information may be disclosed: We may use and disclose personal and identifiable health information for a variety of purposes including treatment planning, billing and health care operations (such as internal audits). We sometimes work with outside business associates. We may disclose your health information, so they can perform the tasks that we hire them to do. They must promise to respect the confidentiality of your personal and identifiable health information. We are required by law to provide information in cases of review by the Secretary of Health and Human Services in determining our compliance with privacy laws or when served a subpoena, court order or warrant. We also may disclose information in cases of public health issues, child or other abuse cases, or if necessary, to prevent a serious health and safety threat to yourself or others. Your information may be released to workers' compensation or similar programs, which provide benefits for work related injuries or illnesses without regard to fault. If you are an inmate, we may release protected information to the correctional institution if it is deemed necessary for your treatment or the health and safety to yourself or others. Your personal information may be used by the office to contact you regarding upcoming or missed appointments, or to give updates on insurance issues, test results and treatment options. We may disclose information to the individuals involved in your care including your spouse, your doctors or an aide who may be providing services to you. In case of an emergency, we may make disclosures without your agreement. If you sign an authorization to disclose information to another individual or company, you may revoke it in writing and stop any future uses and disclosures.

Individual rights: You have the right to ask for restrictions on the way we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting in your care or payment for your care. We will consider your request but are not required to accept it. You have the right to request that you receive communications containing your personal information by alternative means or locations (such as only by mail or only at home). Such requests must be made in writing. If you believe information in your record is incorrect or incomplete, you have the right to ask us to correct or amend the information. Under certain circumstances, we may deny your request. Under certain circumstances, you have the right to inspect and obtain copies of your medical records and billing information. You may be charged a fee for copying and mailing. You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make, and used and disclosed before April 12, 2003, among others. If you ask for this information more than once every 12 months, you may be charged a fee. You have the right to a copy of this notice in paper form at any time. You have the right to be notified if a breach has occurred containing your PHI. To exercise any of your rights, please notify us in writing at Harbor Retina Center 3273 Davison Rd. Suite #1, Lapeer MI 48446

Complaints: If you have any complaints regarding our privacy practices, you may contact our privacy officer at the above address, or the Secretary of the Department of Health and Human Services at 200 Independence Ave, Room 509F, HHH Bldg., Washington DC, 20201. You will not be penalized for filing a complaint. We reserve the right to make changes to this notice at any time. In the event of a change, the revised notice will be posted. You may also request a copy.

PATIENT ACKNOWLEGEMENT: I acknowledge that I have read and understand the Notices of Privacy Practices for Harbor Retina Center. I authorize Harbor Retina Center to obtain and/or release my personal medical history and/or necessary medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location during treatment under Harbor Retina Center for the purpose of carrying out my treatment, payment, and health care operations. This information may include physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS and/or psychological information.

Patient Signature _____**Date**_____

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MEDICAL CONSENT

I, the undersigned, being the person whose name appears hereafter designated as patient or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Harbor Retina Center ("Doctor Office") to (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by a member of my doctor's staff as well as by the doctor him (her)self and this routine work-up often include the instillation of eye drops for various reasons - such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, physician assistants, interns/students/nurses/nurse's aides, technicians and agents and employees of the Doctor's Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient.The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here DOES NOT extend to initiation of any oral or IV medication nor any surgical procedures,injections or lasers performed whether in the office or at a surgical facility. Separate consent must be obtained for any of these procedures.

PRIOR AUTHORIZATION

I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. NOTICE: Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services at the Doctor's Office. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage and any restrictions on choosing a provider. Harbor Retina Center offers a full range of the services you may need; however, in order to receive maximum insurance payment you need to know your health insurance benefits coverage and which providers the insurance will fully pay.

RELEASE OF INFORMATION

The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release shame and copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier (s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request that my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

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HIPAA NOTICE

I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information. DISPOSITION OF TISSUE, ETC. I authorize the Doctor Office to retain, preserve, and use for scientific purposes or disposal at the convenience of the Doctor Office, any specimens or tissues taken during my treatment.

FINANCIAL AGREEMENT

I understand that, even though I may have insurance and authorize this office to submit charges on my behalf, I am financially responsible for all charges not paid by my insurance. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Harbor Retina Center Dr. Deepak Mangla. I hereby authorize said assignee to release all information necessary to secure payment. I am aware that a co-payment may be required for each visit, and if there is no insurance coverage, payment in full is required for services unless prior payment arrangements have been discussed.

This medical facility reserves the right to charge a Returned Check fee of 30.00. If I choose to pay all charges myself and not bill my insurance, I will notify this medical facility prior to receiving service. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether the account is referred to a collection agency

MISSED APPOINTMENTS

I agree to pay the cost for all visits missed or canceled late unless I notify Harbor Retina Center of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me. These fees will not be billed to my insurance. Notify your provider no less than 24 hours in advance of any cancellations. Appointments are the responsibility of the client and/ or parents and reminders from the provider should not be expected. If you cancel or miss an appointment without proper notice, you will be charged a $25 no-show fee and will not be allowed to reschedule until that fee is paid.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

***Signature of Patient/Legal Representative*:**

X_____ Date:_____

Printed Name: _____

Relation (if patient is not guarantor):_____

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Permission to Verbally Discuss Protected Health Information

Patient Name:_____ **Date of Birth:**_____

I give permission to Harbor Retina Center to discuss the following medical and billing information about me which will include:

- Scheduling/appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/test results
- Billing and payment information

Harbor Retina Center has my permission to discuss the above information with:

NAME	PHONE	RELATIONSHIP TO PATIENT

I understand that I may cancel this permission at any time, but that cancelling it will not affect any information that has already been released.

_____

Signature of patient/guardian **Date**

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information before we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parents appointment time