MRC Malkani Retina Center

PATIENT INFORMATION

Date: _____ Date of Birth: _____ Age: _____ Marital: _____ Sex: ☐ M ☐ F

Race/Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other: _____

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Permanent
Address if different than above: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Local Phone: _____ Work Phone: _____ Northern Phone: _____

Email Address: _____

S.S. #: _____ Occupation: _____ Place of Employment: _____

In Case of Emergency Notify: _____ Relationship: _____
(Name) (Phone)

Primary Care Physician: _____ Location: _____ Phone #: _____

Pharmacy Name: _____ Location: _____ Phone #: _____

	Yes	No	MEDICAL HISTORY
Eye Injuries in the Past	☐	☐	Explain _____
Eye Surgeries in the Past	☐	☐	Explain _____
Crossed Eyes or "Lazy" Eye as a Child	☐	☐	Explain _____
	Yes	**No**	
Do You Smoke	☐	☐	How Much Per Day _____
Do You Drink Alcohol	☐	☐	How Much Per Day _____

In your ***Biological Family***, to Your Knowledge, Any History of the Following:

	Yes	No	
Amblyopia or "Lazy Eye"	☐	☐	Explain _____
Blindness	☐	☐	Explain _____
Glaucoma	☐	☐	Explain _____
Retinal Detachment	☐	☐	Explain _____
Macular Degeneration	☐	☐	Explain _____

Other _____

ALLERGIES: Medications, Dyes, Food & What Type of Reaction do You Have? _____

MEDICATIONS & SUPPLEMENTS: Please List **All** Medications & Supplements Including Herbal _____

MEDICAL CONDITIONS: (Diabetes, Hypertension, etc..) _____

SURGERIES: Please List All Surgeries In the Last 5 Years _____

9201 Cypress Lake Drive
Ft. Myers, FL 33919

3161 Harbor Blvd., Unit D
Port Charlotte, FL 33952

1855 Veterans Park Drive # 302
Naples, FL 34109

Phone (239) 324-4888 • Fax (877) 717-0096
Toll Free (855) 625-5264

MRC Malkani Retina Center

Consent for purpose of Treatment, Payment & Health Care Operations / HIPAA

1. **CONSENT TO TREAT**: I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Malkani Retina Center and Its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been rnade to me as a result of the treatment of care.

2. ASSIGNMENT AND RELEASE: I have medical insurance and assign directly to Malkani Retina Center physicians all medical benefits, if any, otherwise, payable to me for services rendered. **I understand that I am financially responsible for all charges incurred whether or not paid by insurance**. In the event of default of payment, I agree to pay all costs of collections including attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. FINANCIAL AGREEMENT: I will make every effort to actively assist Malkani Retina Center with securing payment for services rendered for which I am liable. **I understand that Malkani Retina Center submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made.** I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Malkani Retina Center to process insurance claims, I will be responsible to pay Malkani Retina Center in full and standard fees.

4. STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER (PHYSICIAN): I request that payment of authorized insurance benefits be made on my behalf for any services furnished to me by Malkani Retina Center, including physician services. I authorize any holder of medical information about me to release to (My Insurer) any information needed to determine these benefits or the benefits payable for related services.

My "protected health information" Means Health information such as diagnoses, treatment information, medical test results, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS. This consent/authorization will remain in effect until revoked by the responsible party.

_____ ____/____/____

Printed Name of Patient/Authorized Representative Date

_____ _____

Signature of Patient/Authorized Representative Witness

FORT MYERS
9201 Cypress Lake Dr, 33919

NAPLES
1855 Veterans Park Drive, # 302, 34109

PORT CHARLOTTE
3162 Harbor Blvd, Unit D, 33952

Phone: (239) 324-4888 www.mrcmd.com

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information: *I authorize the release of information including the diagnosis, records, examination results, medication dose changes and claims information.*

This information may be released to:

☐ - Spouse _____ ☐ - Child(ren)_____

☐ - Other _____

Messages: Please call ☐ my phone # is _____ --- If unable to reach me:

☐ - You may leave a detailed message OR ☐ - Please leave a message asking me to return your call

E-mail Messages: My e-mail address is _____

☐ - Use my e-mail address to send messages for me to contact the nurse for information

☐ - Use my e-mail to leave detailed messages and information.

☐- Attach Medical records to the e-mail message.

***This Release of Information will remain in effect until terminated by me in writing.**

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

RECEIPT OF HIPAA PRIVACY NOTICE: *I acknowledge that I have received, OR I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice."** I understand the Notice of Privacy may change over time and that the obligations of Malkani retina Center and my rights under it may change.*

Initial: _____ ****The Summary of the Notice of Privacy Practices is available at check-in.****

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