



PATIENT INFORMATION

Chart Number _____

PLEASE PRINT

Today's Date _____

Patient's Name _____
Last Name First Name MI.

Spouse's Name _____

Sex _____ **Birthdate** _____
M / F Month - Day - Year

SS# _____ - _____ - _____

Permanent Mailing Address _____
Street

City _____ **State** _____ **ZIP** _____ **Home Phone** (____) _____

2nd Address _____ **Email** _____
Street We will not share your email with 3rd parties unless you request it

City _____ **State** _____ **ZIP** _____ **Phone** (____) _____

Employer _____ **Phone** (____) _____

Employer's Address _____

In Case of Emergency

Nearest Relative or Friend/Guardian _____ **Phone** (____) _____

Relationship to Patient _____

Primary Care Physician _____

Previous History of Eye Treatment or Exams:

Any Family History of Eye Disease or Eye Surgery:

What problems are you having with your eyes? _____

Referred or recommended by _____

Thank you for choosing The Macula Center and Dana M. Deupree, M.D



MEDICAL HISTORY AND REVIEW FORM

FILE NO: _____

NAME: _____ PHONE: (____) _____ TODAY'S DATE: _____

FAMILY PHYSICIAN: _____ PHONE: (____) _____

PHARMACY: NAME: _____ PHONE: (____) _____

EMERGENCY CONTACT NAME: _____ PHONE: (____) _____

EMAIL ADDRESS: _____

PAST MEDICAL HISTORY: Please check if YES for each of the following:

- | | | | |
|---|---|--|----------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | _____ AGE |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Angina | <input type="checkbox"/> Liver Disease | _____ MALE |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Hepatitis | _____ FEMALE |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | _____ DATE OF BIRTH: _____ |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hiatal Hernia | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diverticulosis | |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Radiation/Chemo | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Diabetes Type I/Type II | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Parkinson's disease | |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Temporal Arteritis | <input type="checkbox"/> Other | |

Have you or a family member been diagnosed with the following?
Check if YES

- Creutzfeldt-Jakob Disease
- Gerstmann-Straussler-Scheinker Disease
- Fatal Familial Insomnia
- Have you received hormone injections to increase your height?

SOCIAL HISTORY: Occupation: _____
 Do you smoke? **NON-SMOKER EX-SMOKER SMOKER**
 Do you drink alcohol? **NONE OCCASION 1-2DAILY 3-4DAILY**
 Substance abuse? **NONE IVDA UNKNOWN**
 Marital status: **MARRIED SINGLE DIVORCED WIDOWED**

HOSPITALIZATIONS/SURGERY: List any previous below:

Surgery	Date
Thyroid/Neck _____	_____
Heart _____	_____
Lung _____	_____
Stomach/Abdomen _____	_____
Cancer _____	_____
Other _____	_____

FAMILY HISTORY: How related
 Diabetes _____ Cancer _____
 High Blood Pressure _____ Stroke _____
 Heart Disease _____
 Ocular Disease – Macular degeneration _____
 Glaucoma _____ Retinal Detachment _____
 Blindness _____
 Other _____

ALLERGIES TO MEDICATIONS:

NO KNOWN ALLERGIES LATEX SENSITIVITY

***** PRESCRIPTION/NON-PRESCRIPTION MEDS: *****

Review of Systems: Do you have these now? If YES, explain:
NO YES

- Fever/Weight loss/Fatigue/Loss of appetite _____
- Hearing Loss/Sore Throat _____
- Chest Pain/ Shortness of Breath _____
- Wheezing/Cough _____
- Excess Thirst/Excessive Urination _____
- Heat Intolerance/Cold Intolerance _____
- Abdominal Pain/Nausea _____

- NO YES
- Pain/Burning on urination/Blood in Urine _____
 - Rash/Change in Mole _____
 - Swelling in the Feet _____
 - Muscle Aches/ Joint Pain/ Difficulty Lying Flat _____
 - Headaches/Scalp Tenderness/Tremor _____
 - Easy Bruising/Prolonged Bleeding _____

FOR OFFICE USE ONLY: REFERRING DOCTOR:

NAME _____ PHONE (____) _____ ADDRESS: _____



RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORD TO BE RELEASED FROM:

Name of Doctor / Hospital / Clinic

Address City State ZIP

Telephone Number

FAX

SEND TO:

Name of Doctor / Hospital / Clinic

Address City State ZIP

Telephone Number

FAX

Patient Signature X _____ Date _____

PRINT: Patient Name _____ S.S.# _____

Patient Address _____

Telephone _____ Date of Birth _____

Chart Number _____

Witness Signature _____ Date _____



**DOCTOR-PATIENT ARBITRATION AGREEMENT
PLEASE READ CAREFULLY**

Your signature on this form is required prior to seeing Dr. Deupree

This agreement is made between The Macula Center, Dana M. Deupree, other medical physicians, physician assistants, their agents, employees, or any of the foregoing, referred to hereafter as “Doctor” and referred to hereafter as the “Patient”. It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving claims through or on behalf of the patient.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of fees, or any other matter whatsoever then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. This arbitration shall be binding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for us under Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction in and for Pinellas County, Florida. Requests for arbitration by either party must be made within the time frame set forth in section 95.11 of the Florida Statutes dealing with medical malpractice. All arbitration awards for all claims against any parties of The Macula Center shall be limited to \$100,000.00 total. This amount shall include all fees, awards, damage and costs.

This agreement shall remain in effect for all treatment and/or surgery provided the patient presently and at any future date.

Your signature on this form is required prior to seeing Dr. Deupree.

In witness whereof (we) have set our hands this date _____.

Doctor: Dana M. Deupree, M.D.

Patient: X
Patient Signature

By: _____
Authorized agent

By: _____
Chart Number



3280 N. McMullen Booth Rd, Ste 120, Clearwater, FL 33761 727.789.8770

Patient History Update Form

Patient name _____ **Chart #** _____ **Date** _____

	No update (✓)	Updated (new) information
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Name _____

Address _____

Email _____

Race White | Hispanic/Latino | Black/African American | Am. Indian
Asian or Pacific Islander | Middle Eastern | Hawaiian | Decline

Ethnicity _____ θ Of Hispanic origin θ NOT of Hispanic origin

Pharmacy name/address/ph _____

Past Medical history _____

Past Surgical history _____

Smoking _____

Alcohol consumption _____

Other drugs _____

New allergies to meds _____

Prescription changes _____

THE MACULA CENTER FINANCIAL POLICY

Thank you for choosing The Macula Center as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we need your help to ensure your insurance benefits are maximized. The following is a statement of our Financial Policy which you will need to read and sign prior to any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our office.

For patients with insurance coverage, including Medicare

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s): You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies regarding how often services may be rendered and, more importantly, where those services may be performed. Even within the same insurance company, plans can offer different benefits, depending on what your employer has negotiated. We strongly urge you to be familiar with your policy benefits.

Patient Responsibility

All co-pays required by your insurance company must be paid at the time of service. This payment is a requirement by your insurance company. Our office policy allows us to also collect co-insurance, and or deductible amounts at the time of service. All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of benefits from your insurance carrier. If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

For patients with no insurance coverage

If you do not have insurance coverage, payment for services is expected at the time services are rendered.

For patients under Workers' Compensation

We accept assignment of insurance benefits for patients covered under workers' compensation. We will schedule an appointment after being notified from your employer or workers' compensation company. They will provide a claim number and address where to file the claim. The Insurance information and the contact to call to obtain authorization for services is necessary prior to your visit. You are responsible to inform us if your visit is related to a workers' compensation injury.

Patients involved in an automobile or other accident

We accept assignment of insurance benefits for patients involved in an auto accident upon doctor's approval. If it is approved, we will need the claim number, date of accident and address for the claims department before scheduling an appointment. We will file a claim with your auto insurance company for any services you receive. It is your health insurance company's responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident.

We cannot bill the insurance company unless you give us the insurance information and a copy of your insurance card(s). You are responsible to inform us if your visit is related to an auto accident. The balance of your account is your responsibility regardless of payment from your insurance carrier. Your insurance policy is a contract between you and the insurance company. If your insurance company has not paid your account in full within 90 days from the date of service, the balance will be automatically transferred to you. We will not accept assignment from any other third party in relation to an automobile accident.

When all auto benefits are exhausted, we will file claims with your health insurance. If you are not insured, you will be responsible for all charges at the time of service.

Contact Information

Following your visit to the office we will file a claim with your insurance company if you have coverage. After we have received payment from your insurance company you may receive a statement showing any balance due from you. This amount is your responsibility and is due within 30 days of the statement date. We accept cash, checks, Visa, MasterCard, Discover American Express and Care Credit. If you have any questions regarding the balance on your account, please call our business office at 727-789-8770.

Patient name

Signature of Patient or Responsible Party

Date

COMMERCIAL INSURANCE

I authorize The Macula Center., to release to my health insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #

MEDICARE

I authorize The Macula Center to release to Medicare and its agents, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #

MEDIGAP (Medicare Supplemental Policies)

I request payment of authorized Medigap benefits be made on my behalf to The Macula Center, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits.

Patient name

Chart #

Worker's Compensation

I request payment of authorized Worker's Compensation benefits be made on my behalf to The Macula Center for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Worker's Compensation insurer any information needed to determine these benefits.

Patient name

Chart #

AUTO INSURANCE

I authorize The Macula Center., to release to my auto insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #



HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____	Phone Number: _____
Name _____	Phone Number: _____
Name _____	Phone Number: _____
Name _____	Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name _____	Phone Number: _____
Name _____	Phone Number: _____
Name _____	Phone Number: _____
Name _____	Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home. (Confidential Communications)***

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: Yes: No:

5. Please print the telephone number or email address where you want to receive calls about your appointments, test results or other health care information if other than your home phone number:

Phone: (_____) _____ Email Address: _____@_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes: _____ No: _____

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE DATE

DATE



HIPAA NOTICE OF PRIVACY PRACTICES

Suncoast Retina Consultants, LLC DBA The Macula Center

Effective Date: March 26, 2013

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.

You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at The Macula Center.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to

communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

- Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

- Use or Disclosure of Psychotherapy Notes. *Written* authorization is required if our practice intends to use or disclose psychotherapy notes.

- Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

- 1) CBL Path Laboratory

VI. Our Duties.

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.

You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.

You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Louise Christie at The Macula Center.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

