RETINA ASSOCIATES, P.A.
Mansoor Mughal, M.D.
Board Certified Vitreo-Retinal Surgeon
Diseases and Surgery of the Retina, Macula and Vitreous

Welcome to our practice!

An appointment as been scheduled for you with Dr. Mansoor Mughal on:

_____at _____

at the following location:

- ☐ 2 Shircliff Way, Suite 715 • Jacksonville, FL 32204
- ☐ 3636 University Boulevard South, Suite A-6 • Jacksonville, FL 32216
- ☐ 1563 Kingsley Avenue, Suite 101 • Orange Park, FL 32073

Should you need additional directions, please call us. If your appointment is scheduled at our St. Vincent's Riverside office, the DePaul Parking Garage is located at the foot of Shircliff Way on the LEFT.

Please complete the enclosed new patient forms and bring them to your appointment along with:

- **Photo ID**
- **Insurance card(s)**
- **Complete list of medications and eye drops (both prescription and over-the-counter)**

We also recommend having someone drive you as your eyes will be dilated for all your exams.

If you have any questions regarding the information above, or if we can be of further assistance, please call our office at (904) 388-8446. We look forward to meeting you.

Sincerely, Retina Associates, P.A.

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Name: _____

Address: _____ Apt/Unit: _____

City, State & Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Gender: _____ Preferred Language: _____

Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Race: □ Black, African American □ Asian □ White □ American Indian/Alaska Native
□ Native Hawaiian/Pacific Islander □ Unknown □ Declined

Ethnicity: □ Hispanic or Latino □ Not-Hispanic or Latino □ Unknown □ Declined

Pharmacy Name: _____

Pharmacy Address & Phone: _____

Emergency Contact(s):

Name of Person	Relationship to Patient	Phone
Name of Person	Relationship to Patient	Phone

If patient is a minor:

Name of Parent/Guardian	Relationship to Patient	Phone
Name of Parent/Guardian	Relationship to Patient	Phone

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Insurance Information:

Primary Insurance	Policy Number
Subscriber's Name	**Relationship to Patient**
Subscriber's DOB	**Subscriber's SSN**
Secondary Insurance	Policy Number
Subscriber's Name	**Relationship to Patient**
Subscriber's DOB	**Subscriber's SSN**

I hereby authorize my insurance benefit to be paid directly to Retina Associates, P.A. for any services furnished to me. I acknowledge financial responsibility for non-covered services. I also authorize the physician to release any information required to process this claim.

Patient's Signature _____ Date _____

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Financial Arrangements

INSURANCE/PAYMENTS/REFERRALS: Having a copy of your insurance card(s) and photo ID will help us to file insurance claims for services performed during your visit(s).

You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit unless prior arrangements have been made. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.

If you are a self-pay patient, you will be expected to pay for services in full at the time that services are rendered. Please make us aware of any changes to your insurance or mailing address.

If your insurance requires a referral, it is **your** responsibility to obtain one from your primary care physician. Without this prior authorization, the insurance company will not pay for your visit, and we WILL NOT be able to see you. **Regardless of insurance, payment for services remains your personal responsibility.**

I have read and understand the above financial policy.

Printed name: _____

Signature: _____

Date: _____

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Informed Consent for Dilation

Dilating drops are used to enlarge the pupils of your eyes. This allows and Dr. Mansoor Mughal to get a better view the inside of your eye(s).

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for the physician or staff of Retina Associates, P.A. to predict how much your vision will be affected. **Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.**

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Mansoor Mughal and/or the staff of Retina Associates, P.A. to administer dilating eye drops as the eye drops are necessary to diagnose my condition.

Patient Signature _____ Date _____

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Release of Information

I authorize Dr. Mansoor Mughal and/or the staff of Retina Associates, P.A. to release information concerning the status of my health care, information about findings resulting from my eye exam(s), my plan of treatment, as well as billing and appointment information with:

Referring Physician	**Office Phone**
Primary Care Physician	**Office Phone**
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient
Name of Person	Relationship to Patient

Patient or Guardian's Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of September 23, 2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer / Practice Administrator (at 2 Shircliff Way, Suite 715, Jacksonville, FL 32204, phone 904.388.8446) with any questions, comments, or complaints or to exercise any of your rights.

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Acknowledgement and Receipt of Notice of Privacy Practices

I have received a copy of Retina Associates, P.A.'s Notice of Privacy Practices effective September 23, 2013.

Name (please print) _____

Signature _____ **Date** _____

OR If the patient is a minor:

I am a parent or legal guardian of _____ (patient name). I have received a copy of Retina Associates, P.A.'s Notice of Privacy Practices effective September 23, 2013.

Name (please print) _____

Relationship to Patient ☐ Parent ☐ Legal Guardian

Signature _____ Date _____

Office Use Only

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on: _____
Date

☐ In Person ☐ By Mail ☐ Other _____

Reason individual or parent/guardian did NOT sign this form:

☐ Refused

☐ Did NOT respond after more than one attempt

☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In-Person Conversation _____

☐ Telephone Contact _____

☐ By Mail _____

☐ Other _____

Staff Name (print) _____ Position/Title _____

Signature _____ Date _____