PARUL S. DESAI, M.D.

Mid Valley Retina Center

PATIENT IFORMATION

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

SSN#: _____ **Marital Status:** _____ **Male:** ___ **Female:** ___

E-mail: _____ **Employment: (circle) YES NO STUDENT**

Referring Physician: _____ **Family Physician:** _____

Preferred Pharmacy Name / Phone Number _____

DEMOGRAPHIC INFORMATION (necessary for electronic medical record)

Race: _____ **Ethnicity:** _____ **Language: English** ___ **Spanish** ___ **Other** ___

PARENT INFORMATION (for children only)

Parent Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Contact Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Relationship:** _____

Acknowledgement of HIPAA

I hereby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPPA notice of privacy practices provided by the staff of this office. _____

Medicare / Medicaid Assignment of Benefits

I certify that the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that the payment of authorized benefits be made on my behalf. _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Mid Valley Retina Center for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance remaining after my insurance has processed payment and / or if my insurance is invalid. _____

_____ _____

SIGNATURE RELATIONSHIP **DATE**

PARUL S. DESAI, M.D.

Mid Valley Retina Center

INFORMACION DEL PACIENTE

Nombre: _____ **FDN:** _____

Dirección: _____ **Ciudad:** _____ **Estado:** _____ **Código Postal:** _____

Tele de casa: _____ **Tele de trabajo:** _____ **Celular:** _____

SSN#: _____ **Estado Civil:** _____ **Hombre:** ___ **Mujer:** ___

E-mail: _____ **Empleado: (indique) SI NO ESTUDIANTE**

Médico Remitente: _____ **Médico Familiar:** _____

Farmacia Preferida / Teléfono: _____

INFORMACION DEMOGRAFICA (es necesario de registro medico eletrónico)

Raza: _____ **Etnia:** _____ **Idioma: Inglés** ___ **Español** ___ **Otra** ___

INFORMACION DE LOS PADRES (solo para niños)

Nombre de P/Madre: _____ Tele: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal: _____

CONTACTO DE EMERGENCIA

Nombre: _____ **Dirección:** _____

Ciudad: _____ **Estado:** _____ **Código Postal:** _____

Tele: _____ **Relación:** _____

Acuse de recibo de HIPAA

Por la presente reconozco que he revisado completamente y/o ha recibido una copia completa de la notificación de las prácticas de privacidad de HIPAA proporcionada por el personal de esta oficina. _____

Asignación de Beneficios del Seguro Medicare / Medicaid

Yo certifico que la información dada por mí en la aplicación de pago es correcta. Yo autorizo la liberación de todos los registros bajo petición. Solicito que el pago de beneficios autorizados se hagan en mi nombre. _____

Asignación de Beneficios del Seguro

Por la presente autorizo el pago directo de beneficios medicos a Mid Valley Retina Center por los servicios prestados por los proveedores de servicios medicos en la corporación. Entiendo que soy financieramente responsable de cualquier saldo restante después de que mi seguro ha procesado el pago y/o si mi seguro no es válido. _____

_____ _____

SIGNATURE RELATIONSHIP **DATE**

Parul S. Desai, MD

Midvalley Retina Center

Payment Policy

Thank you for choosing us as your ophthalmology care provider. We are committed to providing you with quality and affordable health care. Please take a moment to review our Payment Policy.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due and you have not made payment arrangement with our office, you will receive a statement to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

PARUL S. DESAI, M.D.

Mid Valley Retina Center

Board Certified Ophthalmologist

Vitreo Retinal Diseases and Surgeries of the Eye

HIPAA AUTHORIZATION FOR FAMILY MEMBERS/FRIENDS

I, _____, give permission to Parul S. Desai, MD, PA; McAllen Retina Center, to disclose and release my protected health information to the following person(s):

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health information to be disclosed (check all that apply):

□ My complete health record (including but not limited to diagnoses, tests, prognosis, treatment and billing, for all conditions) OR

□ My complete health record, as above, with the exception of the following information (check as appropriate):

- o Alcohol/drug abuse treatment
- o Mental health records
- o Communicable diseases (including HIV and AIDS)
- o Other (please specify):

_____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purpose or related reasons. You may revoke this authorization in writing any time.

This authorization shall be effective until (check one):

□ All past, present, and future periods, OR

□ Date: ____/____/____

_____ _____

Patient's signature Date

2609 W. Trenton Rd. · Edinburg, TX 78539 · P: (956) 686-9777 · F: (956) 686-9778

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Mid Valley Retina Center

Board Certified Ophthalmologist

Vitreo Retinal Diseases and Surgeries of the Eye

HIPAA AUTHORIZATION FOR FAMILY MEMBERS/FRIENDS

Yo, _____, le doy permiso a Parul S. Desai, MD, PA; McAllen Retina Center, para divulgar mi información médica protegida a la(s) siguiente(s) persona(s):

Nombre(s):	Relación:
_____	_____
_____	_____
_____	_____

Información de salud que se revelará (marque todo lo que corresponda):

□ Mi expediente de salud completo (incluyendo pero no limitado a diagnósticos, pruebas, pronóstico, tratamiento y facturación, para todas las condiciones) O

□ Mi historial de salud completo, como el anterior, con la excepción de la siguiente información (marque si es apropiado):

- o Tratamiento de abuso de alcohol y drogas
- o Registros de salud mental
- o Enfermedades contagiosas (incluyendo el VIH y el SIDA)
- o Otro (por favor especifica):

_____

_____

Esta información de salud puede usarse para permitir que las personas que autorizo a conocer y entender mi condición y mi tratamiento o opciones de tratamiento, para tratamiento o consulta, para propósitos de pago de reclamaciones o razones relacionadas. Usted puede revocar esta autorización por escrito en cualquier momento.

Esta autorización estará vigente hasta (marque uno):

□ Todos los períodos pasado, presente y futuro, O

□ Fecha: ____/____/____

_____ _____

Firma del paciente Fecha

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Vitreo Retinal Diseases and Surgeries of the Eye

NAME / NOMBRE: _____ **DOB / FDN:** _____

PLEASE CHECK EITHER YES OR NO / FAVOR DE INDICAR SI O NO

MEDICAL HISTORY / HISTORIAL MEDICO

YES/SI	NO	
☐	☐	DIABETES _____ # OF YEARS / # DE ANOS
☐	☐	INSULIN / INSULINA _____ # OF YEARS/ # DE ANOS
☐	☐	HEART DISEASE / ENFERMEDAD DEL CORAZON
☐	☐	HEART ATTACK / ATAQUE AL CORAZON
☐	☐	STROKE / DERRAME CEREBRAL
☐	☐	HIGH BLOOD PRESSURE / ALTA PRESION ARTERIAL _____ # OF YEARS / # DE ANOS
☐	☐	RHEUMATOID ARTHRITIS / ARTRITIS REUMATICA
☐	☐	KIDNEY DISEASE / ENFERMEDAD DE LOS RINONES
☐	☐	DIALYSIS / DIALISIS _____ # OF YEARS / # DE ANOS
☐	☐	HEPATITIS C
☐	☐	HIV
☐	☐	OTHER BLOOD-BORNE DISEASE/OTRA ENFERMEDAD TRANSMITIDA POR LA SANGRE:

_____

OTHER DISEASE OR DISORDER / OTRA ENFERMEDAD

_____

_____

_____

FAMILY MEDICAL HISTORY:

_____

_____

_____

OCULAR HISTORY / HISTORIAL OCULAR

YES/SI	NO	
☐	☐	CATARACTS / CATARATAS
☐	☐	RETINA DISEASE / ENFERMEDAD RETINIANA
☐	☐	CORNEA DISEASE / ENFERMEDAD EN LA CORNEA
☐	☐	GLAUCOMA
☐	☐	OCULAR INJURY / HERIDA OCULAR _____
☐	☐	OTHER EYE PROBLEM / OTRA PROBLEMA EN LOS OJOS _____

_____

_____

OCULAR SURGERY / CIRUGIA OCULAR

YES/SI	NO	
☐	☐	RETINA
☐	☐	EYE / OJO: _____
☐	☐	CATARACT / CATARATA
☐	☐	EYE / OJO: _____
☐	☐	OTHER / OTRA: _____
☐	☐	EYE / OJO: _____

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EYE DROPS / GOTAS

_____

_____

_____

MEDICATION LIST / LISTA DE MEDICINAS

(Please indicate name and mg / Favor de indicar nombre y mg)

___ SEE ATTACHED LIST

_____

_____

_____

_____

_____

KNOWN DRUG ALLERGIES / ALERGIA DE MEDICINA

___ NO KNOWN DRUG ALLERGY

NAME / NOMBRE	REACTION / REACCION
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY / HISTORIAL QUIRURGICO

(Please indicate date and type of surgery / Favor de indicar fecha y tipo de cirugia)

_____

_____

_____

PLEASE CHECK EITHER YES OR NO / FAVOR DE INDICAR SI O NO

	YES/SI	NO	Explain problem / Explicar problema
Do you live alone / ¿Habita solo(a)?	☐	☐	_____
Do you drive / ¿Conduce?	☐	☐	_____
Do you have visual difficulty when driving? ¿Tiene problema manejando por su vision?	☐	☐	_____
Do you have problems with night driving? ¿Tiene problema manejando de noche?	☐	☐	_____
Do you exercise regulary? Hace ejercicio regularmente?	☐	☐	_____

SOCIAL HISTORY / HISTORIAL SOCIAL

	YES/SI	NO
Do you drink alcohol? / ¿Ingiere alcohol?	☐	☐
Do you smoke? / ¿Fuma?	☐	☐
Do you use street drugs? / ¿Usa drogas ilegales?	☐	☐
Do you have a living will? ¿Tiene testamento?	☐	☐

DATE: _____