Moss J. Fenberg, MD
Sara J. Haug, MD, PhD

Diplomates American Board of Ophthalmology

SOUTHWEST RETINA CONSULTANTS
SPECIALIZED MEDICAL & SURGICAL EYE CARE

270 East 8th Ave. Suite N-101,
Durango, CO
p (970) 828-2200
f (970) 828-2201
www.swretinaconsultants.com

Patient Information Form

Patient Name: _____ **Male** ☐ **Female** ☐

Birth Date: _____ **Social Security #** _____

Patient Address: _____

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

Email address: _____

Preferred Language: ☐ English ☐ Navajo ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ Caucasian ☐ Asian ☐ American Indian/Alaska Native
☐ African American ☐ Native Hawaiian or Other Pacific Islander

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

Employer Name: _____

Employer Address: _____

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

Occupation: _____

Tobacco: ☐ yes ☐ no **Alcohol:** ☐ yes ☐ no **Drug Use:** ☐ yes ☐ no

Hobbies: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse's Name: _____ **Spouse's work number:** _____

Emergency Contact (Someone not living with you)

Name: _____ **Relationship:** _____

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

HOW DID YOU HEAR ABOUT US? ☐ Referral ☐ Family/Friend ☐ Radio ☐ Newspaper

☐ Phone Book ☐ Internet (please specify) _____ ☐ Other _____

NOTICE:
Dr. Fenberg/Haug provide surgical services at 3 locations in the Durango area; Animas Surgical Hospital, Mercy Regional Medical Center, and Physicians Surgery Center. If you need ophthalmic surgery, certain insurance plans may dictate which facility we are allowed to schedule at. Dr. Fenberg/Haug will recommend where they feel your procedure should occur based upon both insurance coverage, and upon the type and complexity of the surgery required. We are required by law to notify you that Dr. Fenberg is one of many physician owners of Animas Surgical Hospital.

Insurance Information

(Please have your insurance cards ready for us to copy)

Primary Insurance Co. Name: _____

Subscriber's Name: _____ **DOB** _____

Policy Number: _____ **Group #:** _____

Secondary Insurance Co. Name: _____

Subscriber's Name: _____ **DOB** _____

Policy Number: _____ **Group #:** _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail or fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128 B of the Social Security Act and 12 U. S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

I understand that if my insurance denies payment or if I have no insurance coverage, that I am financially responsible.

Signature _____ **Date** _____

(Patient or Legal Guardian)

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy/read a copy of the Notices of Privacy Practice for Southwest Retina Consulants (see page 5).

Signature _____ **Date** _____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

[ ] An emergency existed & a signature was not possible at the time.

[ ] The individual refused to sign.

[ ] A copy was mailed with a request for a signature by return mail.

[ ] Unable to communicate with the patient for the following reason:

Prepared by _____ **Signature** _____ **Date** _____

Pt. Name _____ DOB _____ Date _____

FAMILY HISTORY

☐ Retinal Detachment ☐ Macular Degeneration ☐ Lattice Degeneration ☐ Glaucoma ☐ Diabetes

PAST MEDICAL HISTORY (check all that apply)

EYES: Please include a copy of your most recent clinical exam notes.

ENDOCRINE: ☐ Diabetes ☐ Thyroid ☐ Pancreas ☐ OTHER

CARDIOVASCULAR: ☐ Heart Attack ☐ High Blood Pressure ☐ Congestive Heart Failure ☐ Angina ☐ Pacemaker ☐ OTHER

NEUROLOGICAL: ☐ Stroke ☐ Alzheimer's ☐ Dementia ☐ Migraines ☐ Seizures ☐ MS ☐ OTHER

RESPIRATORY: ☐ Asthma ☐ Emphysema ☐ Lung Cancer ☐ OTHER

MUSCOLO-SKELETAL: ☐ Rheumatoid Arthritis ☐ Degenerative Arthritis ☐ Osteoporosis Fibromyalgia ☐ Polymyalgia Rheumatica ☐ OTHER

GENITOURINARY: ☐ Kidney Disease ☐ Prostate ☐ Bladder ☐ Cervical/Ovarian/Uterine ☐ OTHER

HEMATOLOGIC/LYMPHATIC: ☐ Sickle Cell ☐ Leukemia ☐ Anemia ☐ OTHER

IMMUNOLOGIC/INFECTIOUS DISEASE: ☐ HIV ☐ AIDS ☐ Hepatitis ☐ Tuberculosis ☐ OTHER

PSYCHIATRIC: ☐ Depression ☐ Eating Disorders ☐ Schizophrenia ☐ Anxiety ☐ OTHER

CANCER Type: _____

Primary Physician or Specialist: _____

Medications	Taken For	Medications	Taken For

Allergies to Medications: _____

EYE DIAGNOSIS & PRIOR SURGERIES LIST

_____ _____

_____ _____

_____ _____

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____ **Date of Birth:** _____

I HEREBY AUTHORIZE SOUTHWEST RETINA CONSULTANTS TO SHARE:

- ☐ **All of my medical information**
- ☐ **My lab results**
- ☐ **My appointment times, dates, location, and reasons for the visits**
- ☐ **The medications I am taking**
- ☐ **The following information (specify)** _____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ **Relationship:** _____

Full Name: _____ **Relationship:** _____

Full Name: _____ **Relationship:** _____

Full Name: _____ **Relationship:** _____

I understand that I may cancel this consent at any time (by writing to Southwest Retina Consultants, PC,) but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

☐ **When I cancel in writing** **or on** ☐ **Date** _____

If no expiration date or event is specified, this authorization will expire in one (1) year after the date it is signed.

Signature: _____ **Date:** _____
Relationship to minor patient (if parent or legal guardian)* _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney).

Witness: _____ **Date:** _____
*** A minor patient's signature is required for us to share information about care for (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above); (2) alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).**

Moss J. Fenberg, MD
Sara J. Haug, MD, PhD

Diplomates American Board of Ophthalmology

SOUTHWEST RETINA CONSULTANTS
SPECIALIZED MEDICAL & SURGICAL EYE CARE

270 East 8th Ave. Suite N-101,
Durango, CO
p (970) 828-2200
f (970) 828-2201
www.swretinaconsultants.com

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. If you have any questions about this notice please do not hesitate to contact us.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms ofthis Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or obj ect to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with, the law and will be limited to the relevant requirements of the law . You will be notified, as required by law, of any such uses or disclosures.

Public.Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information, The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations; and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises ofthe practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may. also disclose protected health information to a funeral director, as authorized by law, in order to' permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply withworkers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information, A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending oil the circunistances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.