RETINA GROUP OF NEW ENGLAND, PC
NAUMAN A. CHAUDHRY, M.D. ● JUNER COLINA BISCOTTO, M.D.
AMIRFARBOD F. YAZDANYAR, M.D

Date: _____

Dear: _____,

Welcome to Retina Group of New England.

We are glad you have chosen us for your eye care needs and look forward to meeting you on: _____ at _____

In the _____ office.

Enclosed is some information to better prepare you for your visit. Also enclosed are forms that should be completed prior to your arrival.

On the day of your appointment, please bring the following with you:

* Your photo ID;
* Current health insurance cards;
* Completed Patient Information and Health History forms (enclosed);
* A list of any medications, including dosage;
* A list of all medication allergies;
* Name, address and telephone number of your primary physician as well as other physicians involved in your care;
* If you wear eyeglasses or contact lenses, please wear them to the appointment;
* Sunglasses, or we can provide a pair of drop in sun lenses.

Both eyes will be dilated for your appointment. Please be prepared to stay between 2-3 hours for your first visit. Some patients prefer to come with a companion or arrange a ride from the office.

PLEASE NOTE: Payment of co-pays or deductible is expected at the time of the visit unless other arrangements are made in advance. We accept cash, check, MasterCard, Visa, Discover and American Express.

If you have any questions or would like more information, please give us a call at 860-444-1292 or be sure to ask when you are in the office. Thank you again for choosing Retina Group of New England! We look forward to serving you!

Sincerely,
Nauman Chaudhry, MD, Juner Colina-Biscotto, MD and Amirfarbod Yazdanyar, MD

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Dear New Patient:

It is EXTREMELY important that YOU are aware of your insurance coverage. There are multiple insurance plans with which we participate. However, many of these plans have variations in coverage as well as differing rules and regulations. These must be followed if you want your insurance plan to cover (pay) for services.

- **Non-covered services:** Patients must have an understanding of what is covered under their plan. Any services that are not covered are the Patients Responsibility and will be billed accordingly.
- **Co-payments:** All co-pays are due at the time of the office visit. We are required by the insurance company to collect these co-pays. Please come prepared to make such payments.
- **Referrals:** Check with your insurance company as some do require you to initiate an insurance referral with your primary care physician (PCP). Its is your responsibility to do so. (this information may be located on your card)
- **Pre-certification:** Patients should verify if any pre-certification or approval is needed for any treatment, procedures or lab work. Please inform us if pre-certification is required. Our office will work with you to obtain these approvals.
- **Lab Work:** Sometimes insurances require that patients use specific laboratories when lab work is ordered. The patient is responsible for knowing this information and informing the office. If the office is not informed, the patient will be responsible for any charges incurred.
- **Pharmacy:** Some insurances require that patients use specific pharmacies for medications. The patient is responsible for knowing this information and informing the office.
- **Work-related Injuries:** For work-related injuries, please obtain authorization from your employer prior to coming to your visit. You will need to have the following information: claim #, contact name, contact phone # and the date of the injury.

We will make every effort to help you with the above but cannot guarantee we will know every rule and regulation. Your co-operation is needed in order for us to best serve your healthcare needs and insure you receive all the insurance coverage to which you are entitled.

Thank you,
The Team at Retina Group of New England

174 Cross Road
Waterford, CT 06385
(P) 860-444-1292
(F) 860-444-1827

79 Wawecus St, Ste 109
Norwich, CT 06360
(P) 860-887-6429
(F) 860-887-7303

5 Durham Rd, Bldg. 1 Ste A6
Guilford, CT 06437
(P) 203-458-0245
(F) 860-444-1827

Version 8.1.23

Waterford – 174 Cross Road

(P) 860-444-1292 (F) 860-444-1827

Heading North on I-95:
Take Exit 81 towards Cross Road.
End of the ramp turn left onto Waterford Pkwy S
At traffic light, turn left onto Cross Road.
174 Cross Road is on your left between Shipman's and Curtin Livery.

Heading South on I-95:
Take Exit 82 for CT-85.
Turn right onto CT-85/Hartford Tpke towards Colchester.
Continue past Mall/shopping plazas and take a left onto Cross Road. 174 Cross Road is on your right, between Curtin Livery and Shipman's.

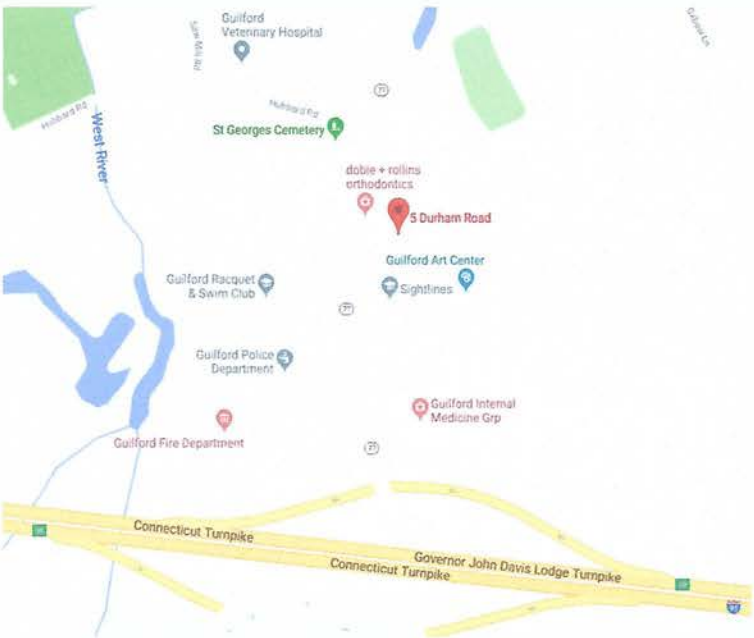
Norwich – 79 Wawecus St, Suite 109

(P)860-887-6429 (F)860-887-7303

Heading North on 395:
Take Exit 14(old exit 82) towards Yantic/Norwichtown.
Turn left onto W. Town St. Take first left onto Wawecus St. 79 Wawecus is on your right.

Heading South on 395:
Take Exit 14(old exit 82) towards CT-2W/CT-32. Hartford/Colchester.
Take the first right onto Wawecus, 79 is on right.

From Route 2E:
Take Exit 27 towards Yantic, turn left onto CT-32.
Stay straight to go onto W. Town St.
Take the first right into Otrobando Ave, then right onto Wawecus, 79 is on right.



Guilford – 5 Durham Rd, Bldg 1 Suite A6

(P)860-444-1292 (F)860-444-1827

Heading North on I-95:
Take Exit 58 for CT-77 toward Guilford/North Guilford.
Turn left onto CT-77 N/Church St/Durham Rd.
Office is located on the right-hand side in the Guilford Glen complex. (1st Building on the right as you enter complex)

Heading South on I-95:
Take Exit 58 for CT-77 N. Turn right onto CT-77 N/Durham Rd.
Office is located on the right-hand side in the Guilford Glen complex.
(1st Building on the right as you enter complex)

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AMIRFARBOD F. YAZDANYAR, M.D

Patient Demographics

Date: _____

Name: _____ SEX: MALE FEMALE

Address: _____ DOB ____ / ____ / ____

City, State: _____ Zip Code: _____ Age: ____

Home phone: (____) _____ Marital status: _____

Cell phone: (____) _____ Work phone: (____) _____

Email: _____

Emergency Contact: _____

Emergency Contact phone: (____) _____

Pharmacy: _____ phone: (____) _____

Address: _____

Primary Care Physician: _____ phone: (____) _____

Address: _____

Referring Physician: _____ phone: (____) _____

Address: _____

Primary Insurance: _____ ID#: _____

Subscriber: _____ DOB: ____ / ____ / ____

Secondary Insurance ID#: _____ ID#: _____

Subscriber: _____ DOB: ____ / ____ / ____

Workers Comp Date of Accident: ____ / ____ / ____

Comp Insurance: _____ ID#: _____

Comp Contact: _____ phone: (____) _____

Thank you for answering the following Medicare required demographics:

Social Security Number _____ - _____ - _____

1. What is your preferred language? _____

2. What is your ethnicity?
    a) Hispanic or Latino
    b) Not Hispanic or Latino
    c) Unreported or Refused to Report

3. What is your race?
    a) Asian
    b) Native Hawaiian
    c) Other Pacific Islander
    d) Black or African American
    e) American Indian or Alaskan Native
    f) White
    g) More than 1 race
    h) Unreported or Refused to Report

Patient Signature: _____ Date: _____

***Preferred method of receiving appointment reminders: (please select one):

☐Call Home Phone ☐Call Cell Phone ☐Text ☐Email

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AMIRFARBOD F. YAZDANYAR, M.D

Health History

Date: _____

Name: _____

Date of Birth: _____

Purpose of your visit: _____

List of all allergies to medications: _____

_____

➢ Are you allergic to Latex?	YES	NO
➢ Do you have macular degeneration?	YES	NO
➢ Do you have glaucoma?	YES	NO
➢ Do you have cataracts?	YES	NO
➢ Have you ever had an eye surgery?	YES	NO
➢ Have you ever had an eye injury?	YES	NO
➢ Have you ever had temporary loss of vision?	YES	NO
➢ Have you ever had a lazy eye?	YES	NO
➢ Do you have diabetes?	YES	NO
➢ Have you been diagnosed with high blood pressure?	YES	NO
➢ Do you have any heart trouble?	YES	NO
➢ Have you ever been diagnosed with lung problems?	YES	NO
➢ Have you had a stroke?	YES	NO
➢ Have you ever had stomach or intestinal issues?	YES	NO
➢ Have you ever had urinary tract issues?	YES	NO
➢ Have you ever been diagnosed with cancer?	YES	NO
➢ Have you been diagnosed with thyroid disease?	YES	NO
➢ Do you have ANY bleeding problems?	YES	NO
➢ Do you have arthritis?	YES	NO
➢ Have you ever been hospitalized?	YES	NO
➢ Have you ever used IV drugs outside of a hospital setting?	YES	NO
➢ Have you had recent weight gain/loss?	YES	NO
➢ Have you had a recent fever?	YES	NO
➢ Do you have any skin conditions?	YES	NO
➢ Do you have any problems with your ears, nose or throat?	YES	NO
➢ Do you have mouth sores or problems swallowing?	YES	NO
➢ Have you ever had any treatment for psychiatric disorders?	YES	NO
➢ Are you pregnant or breastfeeding?	YES	NO
➢ Are you post-menopausal? Since _____ (year)	YES	NO
➢ Have you ever smoked?	YES	NO

(If yes)Number of packs a day _____ How many years have you smoked?_____
What year did you stop? _____

Please list details to ANY "YES" answers from the previous page: _____

_____

_____

_____

Please list all previous surgeries (including eye) and dates: _____

_____

_____

_____

Current occupation: _____

Have you traveled in the last 6 months? If YES, where? _____

Please list current medications, vitamins and doses (INCLUDING BIRTH CONTROL):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a family history of:

1.	Diabetes	YES	NO
2.	Retinal Detachment	YES	NO
3.	Glaucoma	YES	NO
4.	Macular Degeneration	YES	NO
5.	Rheumatoid Arthritis	YES	NO
6.	Cancer	YES	NO
7.	High Blood Pressure	YES	NO
8.	Other? _____		

Any other comments: _____

_____

_____

_____

Patient Signature: _____ Date: _____

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Signature on File, Assignment of Benefits, Financial Agreement MR#:_____

Beneficiary (patient) _____

Please read both sides of this form and sign on the reverse side

1) **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Retina Group of New England, PC, for services furnished to me by Retina Group of New England. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made to Retina Group of New England and it authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in *Item 9 of the HCFA 1500 form* or elsewhere on other approved forms, my signature authorizes releasing this information to the insurer or agency shown. Retina Group of New England, PC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based on the charge determination of the Medicare carrier.
2) **MEDIGAP:** I understand that if my Medigap policy or any other health insurance is indicated on *Item 9 of the HCFA 1500 form* or on another approved claim form, my signature now authorizes the release of information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Retina Group of New England, PC.
3) **RELEASE OF INFORMATION:** Retina Group of New England, PC may disclose all or any part of my medical record and/or financial ledge, including information regarding alcohol or drug abuse, psychiatric illness, communicable diseases or HIV to any person or corporation (1)which is or may be liable under contract to Retina Group of New England, PC for reimbursement for services rendered, and (2)any healthcare provider for continued patient care. Retina Group of New England, PC may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical research, or the collection of statistical data pursuant to State and Federal Law, statute or regulation. A copy of this authorization may be used in place of the original.
4) **OTHER INSURANCES:** I understand that Retina Group of New England, PC contracts with specific healthcare service plans and that I am responsible to know if they, Retina Group of New England, PC, are considered contracted providers by my insurance plan.

(Initials): _____**I agree that I am individually obligated to pay the full charges of all services rendered to me by Retina Group of New England, PC if I belong to an insurance plan that does not contract with them.**

5) **NON-COVERED SERVICES:** I understand that Retina Group of New England, PC does contract with healthcare service plans (i.e. HMOs & PPOs) which will pay only related items and services which are acknowledged as **"covered"** by the healthcare plan. **Accordingly, I accept full financial responsibility for all items or services which are determined by the healthcare plan not to be covered.** Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with the healthcare plan or in the benefit summary plan, that the healthcare service plan furnishes to the patient ant treatment or tests not authorized by the healthcare plan. The undersigned agrees to cooperate with Retina Group of New England, PC to obtain necessary healthcare plans authorizations as deemed necessary by the healthcare plan. It is the patient's responsibility to know what services require authorizations.
6) **FINANCIAL AGREEMENT:** I agree that in return for the services provided by Retina Group of New England, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to them for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and/or by a jury in a court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Retina Group of New England, PC. If copayment, coinsurance and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Retina Group of New England, PC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

THE PATIENT HAS READ AND BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS REGARDING ALL 6 SECTIONS. THIS FORM BECOMES PART OF THE PATIENT RECORD.

Patient/Responsible Party *Signature*: _____

Responsible Party Print name: _____

Date: _____ / _____ /_____

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AMIRFARBOD F. YAZDANYAR, M.D

Acknowledgment: Receipt of Notice of Privacy Practices

I have received a copy of Retina Group of New England, PC's Notice of Privacy Practices effective January 1, 2016.

Name (print): _____

Signature: _____ Date: ____ / ____ /____

I am a parent or legal guardian of _____ (patient).

I have received a copy of Retina Group of New England, PC's Notice of Privacy Practices effective January 1, 2016.

Name (print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: ____ / ____ / ____

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 made to obtain it.

Notice of Privacy Practices effective January 1, 2016 given to individual
☐ In Person ☐ Mailing ☐ Email ☐ Other _____
on ____ / ____ / ____

Reason Individual or parent/legal guardian did not sign this form:
☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

Please document with dates, times, individuals spoken to, and outcome, as applicable, the good faith efforts that were made to obtain the individual/legal guardian signature. More than one attempt must be made.
☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing/Email _____
☐ Other _____
Staff Name: _____ Title: _____
Signature: _____ Date: ____ / ____ / ____

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Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: Retina Group of New England, PC

Patient Name: _____

Social Security #: _____ Date of Birth: ____ / ____ / ____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Representative: _____

Address: _____

_____ Phone: _____

- Description of information to be disclosed: I authorize the practice to disclose all my protected health information to my designated representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

  Retina Group of New England, PC
  174 Cross Road
  Waterford, CT 06385
  Attn: Privacy Manager

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Patient Signature: _____ Date: ____ / ____ / ____

Copies of signed authorizations are available upon request

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CONSENT AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, FILMS, MEDICAL IMAGES, AND OTHER MULTIMEDIA FOR EDUCATIONAL/RESEARCH PURPOSES

MRN:_____
Patient Name:_____

Purpose:
We ask your permission to take photographs and/or create multimedia items that contain health information about you. The multimedia item will be taken or made during the course of a healthcare treatment you may receive from RGNE. We want to share this information about you with other individuals and entities either inside or outside of RGNE for educational purposes, so that other health sciences professionals and students can learn about your condition or disease. This will benefit other patients.

Confidentiality:
You will **not** be identified by your name. The multimedia item will be edited and stored on a computer without your name.

Revoking your permission:
You may change your mind and withdraw your permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke your permission, write a letter, sign it, and deliver it to Retina Group of New England, PC. The revocation letter will take effect when RGNE receives it, except to the extent that RGNE or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.

Expiration:
Unless you revoke your permission earlier, the Authorization has no expiration.

I give permission for these items to be taken or made or used:
Standard of Care Ocular Imaging

I give permission to RGNE to use these items for these educational purpose(s):

- Training of health science professionals at RGNE, including students and staff.
- Sharing with (dissemination to) other health science center for use in their educational programs.
- Use in professional publications, presentations and at professional conferences.
- Research study certification of staff and equipment.

I agree that RGNE will own any and all rights in the multimedia items listed above. RGNE will have the right to reproduce, distribute, transmit, publish, exhibit, or otherwise use the multimedia items listed above. I will not receive any payment for any use of them.
I have read this paper about the use of multimedia items that contain my health information. I understand the permission I am giving. My questions have been answered to my satisfaction, and I agree to what this form says. I will get a copy of this form.

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____

Understanding your health insurance policy

Deductibles, Copays & Coinsurance

Deductible = Amount you pay for health care services before your health insurance begins to pay anthing to your provider. You pay all costs/charges until your deductible is "satisfied".

Copay = A set dollar amount determined by your insurance that must be paid to your physician, hospital or pharmacy everytime a service is utilized. (Retina is a "specialty" and may have a different copay than your PCP)

Coinsurance = Your share of the costs of a health care service. It's usually figured as a percentage of the amount your insurance allows to be charged for services. You start paying coinsurance after you've paid your plan's deductible

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Retina Group of New England, PC
www.retinagroupofnewengland.com

Deductibles, Copays & Coinsurance

The less you pay for your monthly insurance premium, usually the higher the deductible.

Let's say your yearly deductible is $2000.

It's January and you have the flu. You see your doctor and his allowable charges are $150. You are responsible for the entire cost because your deductible is not met. You pay $150 at the time of your visit. Now, your remaining deductible is $1850.

It's March and you come to your retina specialist for your checkup. You have worsening disease and need to have a treatment. The specialist's allowable charges are $1700. Your insurance pays $0. You pay the full cost of $1700. Now you have met $1850 (150+1700) of your deductible. You are left with $150 of the deductible that needs to be satisfied.

It's June and you sprained your ankle. You see your podiatrist and he does an x-ray. The allowable charges are $200. You pay the remaining deductible ($150) and your insurance pays the rest.

It's September and you are following up again with your retina specialist. The allowable charges for that visit are $350. Your deductible is "satisfied" for the year. You pay your copay at the time of the visit. Your insurance pays $350.

*If you have a coinsurance your insurance pays a % of the $350 and you pay the remaining percentage. (i.e. 80/20 plan = insurance pays $280, you pay $70)

Retina Group of New England, PC
www.retinagroupofnewengland.com