Mon Tues Wed Thurs Fri

Appt Date: ____/____/____

Time: _____

Clinic: Sartell Alexandria Baxter

CENTRAL MINNESOTA RETINA SPECIALISTS

VITREORETINAL and MACULAR DISEASES and SURGERY

Welcome to our Clinic,

We appreciate you choosing Central Minnesota Retina Specialists for your eye care. We look forward to educating you about your retinal diagnosis and taking care of you.

Initial exams generally take 2-3 hours. There are usually several tests and treatment options that can be done on the same day.

Please take some time to update us about your past medical history and sign the included consent forms. Use the postage paid return envelope or bring your completed forms with you on the day of your appointment.

If you have any questions about your insurance or the billing process, please call our billing department at 1-888-252-3020.

If you have any other questions, please call us at 1-866-667-8585 toll free or 320-230-8555.

We look forward to seeing you.

Sincerely,

Central Minnesota Retina Specialists

www.centralmnretina.com

Flip for Dr. Reynolds Bio

CENTRAL MINNESOTA RETINA SPECIALISTS

VITREORETINAL and MACULAR DISEASES and SURGERY

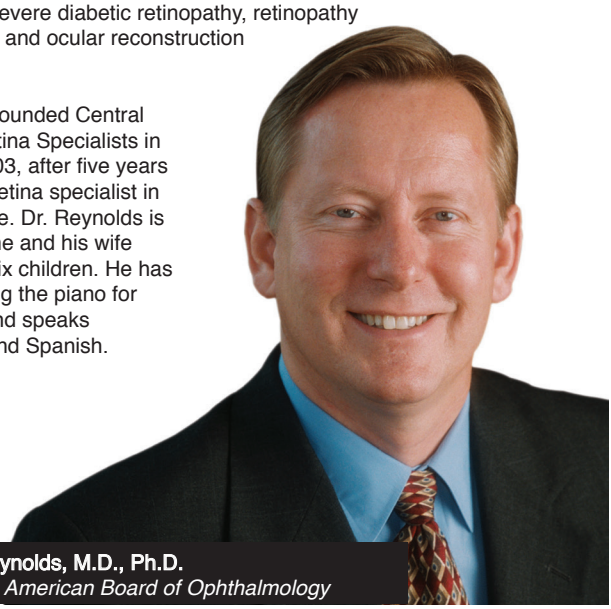
Dr. Reynolds was born in Minneapolis, Minnesota, and his parents and extended family are all from the Alexandria area. His family later moved to San Diego, California where he completed high school and college. In 1983 he graduated Summa Cum Laude with a Bachelor of Science degree in Biomedical Engineering from the University of California at San Diego.

He then went to Harvard University in Boston, Massachusetts, where he earned a Ph.D. in the Division of Medical Sciences, studying immunology. In 1992 he received his M.D. from Harvard Medical School and on graduation was awarded the medical school's Shipley Prize for "best published results of research." Dr. Reynolds was also awarded an Albert Schweitzer Fellowship to travel to Gabon, Africa, where he worked as an intern at the world-famous Albert Schweitzer Hospital in Labarene, Gabon.

Dr. Reynolds next completed an internal medicine internship at the University of California at San Francisco and then an ophthalmology residency at Los Angeles County Hospital/University of Southern California Medical Center and Doheny Eye Institute.

Dr. Reynolds, a Board Certified Ophthalmologist, has also completed subspecialty fellowship training in retina/vitreous diseases and surgery at Bascom Palmer Eye Institute, in Miami, Florida. Bascom Palmer has consistently been ranked as the number one or two ophthalmology training institute in the nation by U.S. News for the past 14 years. Following fellowship training, Dr. Reynolds served as the resident supervisor and chief of vitreoretinal surgery at Los Angeles County Hospital. Dr. Reynolds has extensive surgical experience with retinal detachment, severe diabetic retinopathy, retinopathy of prematurity, and ocular reconstruction after trauma.

Dr. Reynolds founded Central Minnesota Retina Specialists in November 2003, after five years working as a retina specialist in private practice. Dr. Reynolds is married, and he and his wife Ginger have six children. He has enjoyed playing the piano for many years and speaks both French and Spanish.



Dale S. Reynolds, M.D., Ph.D.
Diplomate, American Board of Ophthalmology

1-866-667-8585

2330 Troop Drive, Suite 104, Sartell, MN 56377
www.centralmnretina.com

Central Minnesota Retina Specialists

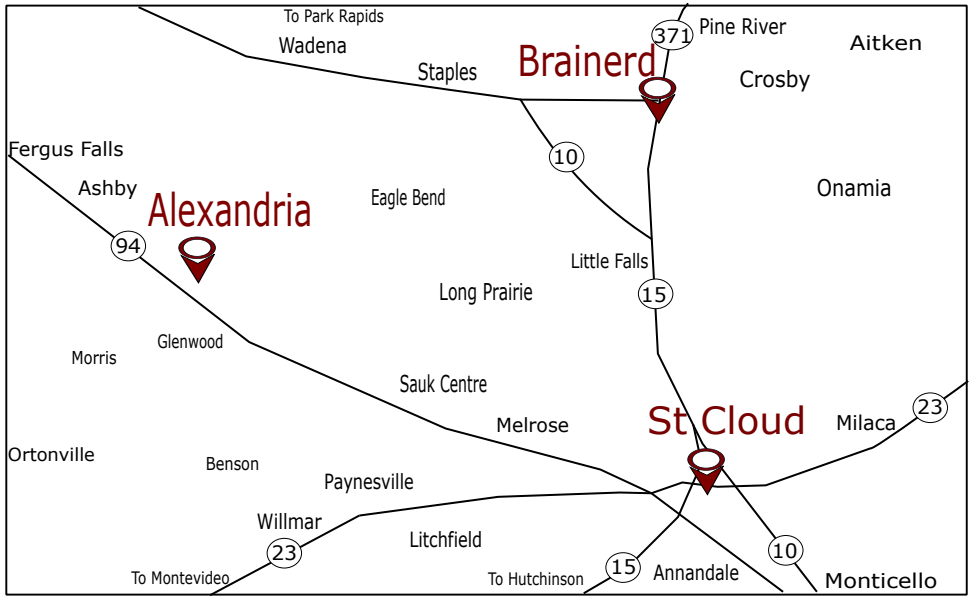
Serving Central Minnesota with Clinics In:

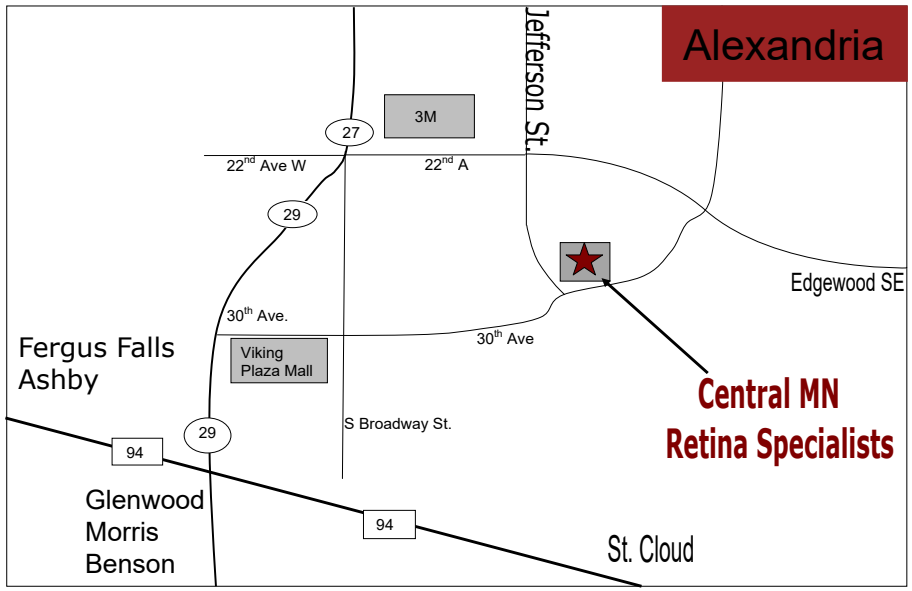
www.centralmnretina.com

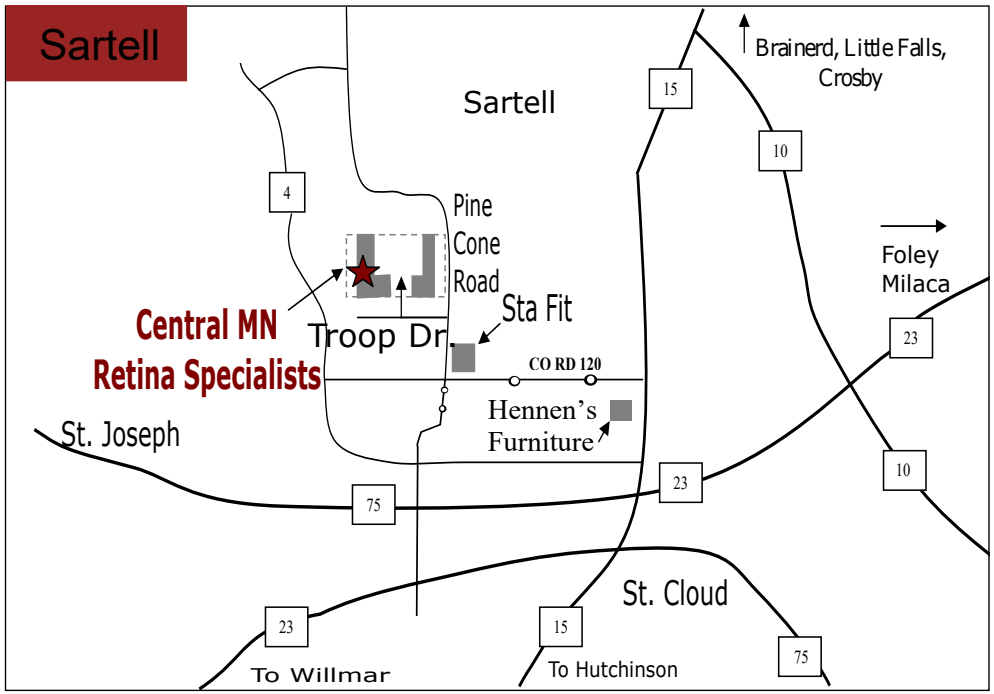
St. Cloud: 2330 Troop Dr. Unit 104, Sartell MN 56377

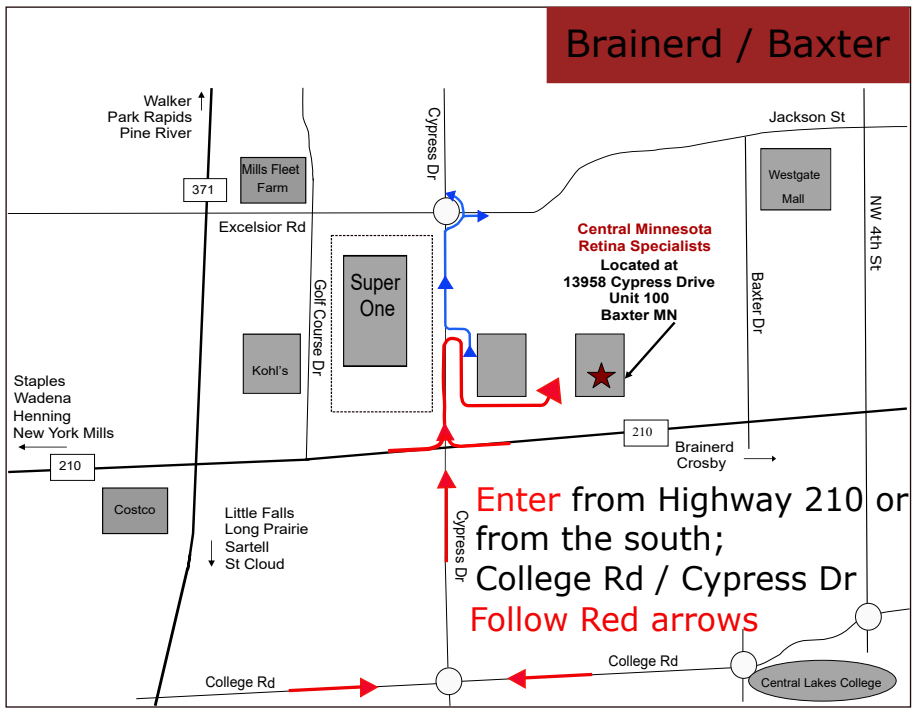
Alexandria: 2633 Jefferson St. Unit 802, Alexandria MN 56308

Brainerd: 13958 Cypress Dr., Baxter MN 56425









Exit is Right turn only on to Cypress Dr. Follow Blue arrows

CENTRAL MINNESOTA RETINA SPECIALISTS
VITREORETINAL and MACULAR DISEASES and SURGERY

Patient Contact Information

First Name: _____ Middle Initial: ____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Birth Date: _____
Alternative Phone: _____ Sex: Male or Female
E-mail Address: _____ Marital Status: _____
Employed__ Retired__ Disabled__ Unemployed__ Occupation: _____
Preferred Language: English__ Other:_____ SS#_____

Emergency Contact Information

Full Name: _____ Relationship: _____
Phone Number (preferably different than patients): _____

Referring Doctor:_____
Clinic Name:_____ City:_____
Phone:_____ Fax:_____

Primary Care Doctor:_____
Clinic Name:_____ City:_____
Phone:_____ Fax:_____

Other Doctor (if applicable):_____ Specialty:_____
Clinic Name:_____ City:_____
Phone:_____ Fax:_____

CURRENT EYE PROBLEM

Chief complaint / symptom?

- ☐ Blurred vision
- ☐ Floaters
- ☐ Loss of vision
- ☐ Flashes
- ☐ Distortion of vision

Other: _____

Which eye? ○ Right ○ Left ○ Both

Onset? ○ Sudden ○ Gradual

How Severe is it? ○ Mild ○ Moderate ○ Severe

Duration of Problem? _____

Location of Problem: ○ Central Vision ○ Entire field of view ○ unable to localize

EYE MEDICATIONS **or check** ☐ None

Eye drop name	How many times per day	Which eye

Complete both sides >>>

PERSONAL MEDICAL CONDITIONS

Please check off all that apply below.

If NONE apply please check the NONE check box

Cardiovascular: ☐**None** ☐ Hypertension ☐ Hyperlipidemia ☐ Heart Disease ☐ Stroke	**Constitutional:** ☐**None** ☐Cancer ☐ Trauma/large blood loss ☐ Developmental disability ☐ Alzheimer's	**Endocrine:** ☐ **None** ☐ Type I Diabetes – Last A1C____ ☐ Type II Diabetes – Last A1C___ ☐ Thyroid problem (high/low) ☐ Hormonal dysfunction
Gastrointestinal: ☐ **None** ☐ Crohn's disease ☐ Colitis	**Genitourinary:** ☐**None** ☐ Kidney disease ☐ Urinary tract infections	**Hematological:** ☐ **None** ☐ Anemia ☐ Leukemia
Ears/Nose/Throat: ☐ **None** ☐ Hearing loss ☐ Upper respiratory infection	**Immunologic:** ☐ **None** ☐ Aids/HIV ☐ Lupus	**Integumentary:** ☐ **None** ☐ Eczema ☐ Psoriasis
Musculoskeletal: ☐**None** ☐ Osteoarthritis ☐ Fibromyalgia	**Neurologic:** ☐**None** ☐Multiple sclerosis ☐ Epilepsy	**Psychiatric:** ☐**None** ☐ Anxiety ☐ Depression
Respiratory: ☐ **None** ☐ Asthma ☐ Tuberculosis ☐ COPD	**Any other medical conditions:** _____ _____ _____	

SURGICAL HISTORY **or check** ☐ **None**

_____

_____

_____

_____

Complete both sides >>>

CURRENT MEDICATIONS or check ☐ None

Encouraged to bring printed list of all medications

- ☐ Aspirin 81 mg
- ☐ Aspirin 325 mg
- ☐ Atenolol
- ☐ Coumadin
- ☐ Hydrochlorothiazide
- ☐ Insulin
- ☐ Lisinopril
- ☐ Metformin
- ☐ Metoprolol
- ☐ Plaquenil
- ☐ Plavix
- ☐ Prednisone

All other medications not listed:

_____

_____

_____

_____

_____

ALLERGIES: or check ☐ None

_____

_____

_____

FAMILY HISTORY or check ☐ None

Please place a check mark in each box that is applicable

	Mother	Father	Sister	Brother	Son	Daughter	Grandmother	Grandfather	Uncle	Aunt
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Smoking/Tobacco:

- ☐ Never smoker
- ☐ Former smoker
- ☐ Current everyday smoker

Alcohol:

- ☐ None
- ☐ Occasional/social
- ☐ 1-2 Drinks a day
  3-4 drinks a day

Substance Abuse:

- ☐ None
- ☐ Other: _____

Complete both sides >>>

OTHER CURRENT SYMPTOMS you are currently experiencing:

If nothing applies please check the **None** check box

Allergy/Immunology:
- ☐ **None**
- ☐ Autoimmune disease
- ☐ Seasonal allergies

Endocrine:
- ☐ **None**
- ☐ Excessive thirst
- ☐ Excessive urination

Hematology/Oncology:
- ☐ **None**
- ☐ Easy bruising
- ☐ Prolonged bleeding

Musculoskeletal:
- ☐ **None**
- ☐ Muscle pain
- ☐ Joint pain

Respiratory:
- ☐ **None**
- ☐ Wheezing
- ☐ Cough

Cardiovascular:
- ☐ **None**
- ☐ Chest pain
- ☐ Shortness of breath

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal pain
- ☐ Nausea

HENT:
- ☐ **None**
- ☐ Hearing loss
- ☐ Sore throat

Neurological:
- ☐ **None**
- ☐ Weakness
- ☐ Headache

List any other current symptoms:

Constitutional:
- ☐ **None**
- ☐ Fever
- ☐ Fatigue

Genitourinary:
- ☐ **None**
- ☐ Pain/burning on urination
- ☐ Blood in urine

Integumentary:
- ☐ **None**
- ☐ Rash
- ☐ Severe itching

Psychiatric:
- ☐ **None**
- ☐ Depression
- ☐ Stress

Have you ever had a blood transfusion? Yes ◯ No ◯

If yes, please explain: _____

Do you have a history of infections blood disorders? Yes ◯ No ◯

If yes, please explain: _____

Do you Drive? Yes ◯ No ◯

Complete both sides >>>

CENTRAL MINNESOTA RETINA SPECIALISTS
VITREORETINAL and MACULAR DISEASES and SURGERY

Authorization to Release Medical Information

I understand that at any time, I may obtain a copy of Central Minnesota Retina Specialists (CMRS) Notice of Privacy Practices.

I authorize CMRS, to release any medical information about me to all my other health care providers. (examples: the doctor who referred you, primary care doctor)

I authorize, CMRS, to release any Protected Health Information about me to the following persons: (Typical choices would be spouse, child(ren), friend)

_____ _____

_____ _____

I authorize CMRS, to release any Protected Health Information about me to my insurance companies and claims clearinghouse as necessary to pay claims for services provided.

I authorize CMRS, to release any Protected Health Information about me to Clinical Registries.

I authorize CMRS, to leave a message, with a call back number or appointment reminder, on voicemail at any phone numbers I provide to CMRS.

Do you have a Medical Power of Attorney? YES or NO
If yes, name of Medical Power of Attorney:_____
Please provide a copy of supporting documents for your medical record.

I certify that this Authorization has been made voluntarily and the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time by completing Central Minnesota Retina Specialists' form, so long as the company has not yet relied upon and/or acted upon Authorization. I understand that information used or disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it. A copy or facsimile of the Authorization with my signature may be used with the same effectiveness as an original.

This authorization and assignment will remain in effect until revoked by me in writing.

Printed name:_____

Signature:_____ Date: _____

Parent or Legal Guardian if Patient is a minor: _____

Relationship to Patient: _____

Insurance Verification

CENTRAL MINNESOTA RETINA SPECIALISTS
VITREORETINAL and MACULAR DISEASES and SURGERY

We are happy to bill your insurance carrier on your behalf for charges you incurred during your visits at Central Minnesota Retina Specialists. In order to do so we need accurate information about your insurance coverage.

Patients with Medicare:
Have you purchased a Medicare Advantage or cost plan? Yes ___ No ____
This is an insurance plan that replaces your Medicare plan. This insurance would be the only insurance used to pay your doctor bills. These are typically offered by private insurers such as Blue Cross Blue Shield, Medica, Humana, etc. If you have a Medicare Advantage or cost plan please only present this insurance card to us and note only one insurance below.

Please call your insurance company to answer the following questions:

How much is your copay?_____
We will collect your co-pay amount at your appointment.

How much is your deductible (if applicable)?_____
We will collect your deductible amount at your appointment. Please call Ashley in our billing office to get an estimate at 1-888-252-3020.

What is your co-insurance % (if applicable)? _____
For example if you pay 20% of charges. **We will collect your co – insurance amount at your appointment. Please call Ashley in our billing office to get an estimate at 1-888-252-3020.**

Does your insurance require a referral or prior authorization? Yes ___ No ___ if yes, please call you primary care physician to obtain one prior to arriving at our office. The referral must be received by us before your appointment.

Do you have two or more insurances?
If yes, please call both of your insurance companies to confirm which insurance pays the bill first.

My only, first, or primary insurance is: _____

My secondary insurance is (if applicable) : _____

I acknowledge that I have presented my insurance coverage to be true and have not falsified or omitted any information.
Please bring your insurance cards to your visits.
Please update Central Minnesota Retinal Specialists with any changes to your insurance coverage

Complete both sides>>>

Patient _____ Date _____

CENTRAL MINNESOTA RETINA SPECIALISTS
VITREORETINAL and MACULAR DISEASES and SURGERY

Billing Policies

Financial Responsibility: I understand and agree that I am financially responsible for payment of any service provided to me, my spouse or to my minor child(ren) not covered by insurance, including but not limited to, deductibles and co-insurance.

Copayments: I understand and agree that it is my responsibility to pay any co-pay listed on my insurance card at the time of service.

Insurance: We participate in a variety of insurance plans and will directly bill your insurance under these plans. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of your medical care within a reasonable time, regardless of status of a claim. Services not covered by your insurance are your responsibility. **I request and agree that payment of authorized insurance benefits be made to Central Minnesota Retina Specialists, for any services rendered.**

Prior Authorization: Some health maintenance organization (HMO) plans require you to obtain authorization for services from your primary care provider (internist, family practitioner, pediatrician, etc.) before you visit our office. *I understand it is my responsibility to obtain authorization from my primary care provider even when the visit is for an urgent problem.*

We Participate with Medicare: We are participating providers under Medicare. This means we accept the fees set by Medicare for medical services covered by the Medicare program, including surgery. Medicare patients will be responsible only for copayments, deductibles and non-covered services, such as refractions and routine eye exams.

I request that payment of authorized Medicare benefits be made on my behalf to Central Minnesota Retina Specialists (CMRS), for services furnished me by CMRS. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorized releasing the information to the insurer or agency shown. CMRS 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 deductible are based upon the charge determination of the Medicare Carrier.

Electronic conversion of check payments: I do hereby authorize Central Minnesota Retina Specialists to initiate a debit, in the amount written on my check, to my checking/savings account at the depository financial institution(Bank) identified by the routing number on my check and bank to debit same to such account. I acknowledge that I have received services/goods in consideration hereof and I further agree that this authorization shall be non-revocable. I agree to pay merchant a returned item fee in accordance with the merchant's return policy, which may be initiated to my account for the items returned unpaid.
Credit card Payments: I agree to pay the above amount according to the card issuer agreement. We accept Visa, MasterCard, American Express and Discover.

Bill Collection: If billing is necessary, a statement will be mailed to you and is due upon receipt. Charges and payments for services received during the last few days before your billing date may appear on the following month's statements. I understand failure to make payment on my bill will result in my account being turned over to a third party collection agency. I understand the fee charged by the collection agency will be added to my bill.

Termination of Care: I acknowledge that an overdue balance of 30 days or more that is not addressed to the satisfaction of Central Minnesota Retina Specialists after notice of default and an opportunity to reach an acceptable payment arrangement may result in Central Minnesota Retina Specialists terminating my care upon written notice.

For answers for further questions, please contact *Ashley at 1-888-252-3020.*

I have read and understand the above stated billing policies and my signature below certifies that I agree to these stated billing policies.

Printed Name:_____

Signature:_____ Date: _____

Complete both sides >>>