RETINA MACULA INSTITUTE

**Ron P. Gallemore, .M.D., Ph.D., Inc.**

**As a new patient to the Retina Macula Institute, Dr. Ron P. Gallemore and his team of professionals would like to welcome you to our Retina family. Your first appointment at the Retina Macula Institute will involve a comprehensive evaluation of the back of your eyes, "The Retina." This includes a detailed history followed by preliminary testing conducted by our staff then an examination of the vitreous and the retina by the physician. Your eyes will be dilated, which means special drops will be used to enlarge the pupils. The pupils are the center black part of the eyes. Dilating your pupil allows the physician to better view the inside of the eye, particularly your vitreous and retina. Please be aware that your vision will be blurry for a period of time. Please set aside at least an hour for your initial consult. If additional tests are required, your visit may go beyond the hour. Please remember to bring a driver with you since dilation of your eyes may interfere with your ability to focus while driving. Any previous eye medical records will be helpful. If you are a diabetic, please remember to bring snacks with you.**

**New patients are expected to bring insurance cards, driver's license or any form of ID, as well as a list of medications that you are on, including eye drops and vitamins. When you sign in, you will be given a packet to fill out about your past and present medical history to ensure the best possible care from the staff. Please complete this to the best of your ability. If you have visual impairment and are unable to complete the form, then please do not hesitate to ask assistance from our staff members. A consult report will be generated at the end of your initial visit, therefore, it is important to provide our staff with the name of your primary care physician and most importantly the name of the doctor who referred you to Dr. Gallemore for a comprehensive retinal evaluation. You may bring your favorite book or magazine since this may help minimize your concerns during the wait. We recognize that your time is valuable, and we make every effort to see you at the appointed time. We appreciate your patience if there is a delay due to unexpected circumstances.**

**Once you have completed your visit as a new patient, it is imperative that you follow through with the physician's recommendations. Successful medical care requires ongoing collaboration between the patient and physician. This partnership requires both individuals to take an active role in the process. As a patient, you are entitled to good quality care and the right to make informed decisions regarding your care. This means the physician will provide you with information about your diagnosis, prognosis, and different treatment choices along with their corresponding risks and benefits. Ultimately, however, you are still in control of the decisions that direct your medical care and have the responsibility of returning as scheduled for your appointments, taking your medications as prescribed, and following through with the agreed upon treatment plan outlined by the physician.**

*Enclosed you will find registration forms that need to be completed, please bring these in on the day of your appointment.*
*Please feel free to call us anytime with your questions or concerns at (310) 944-9393*

*Sincerely,*

*The Scheduling Team*
*Retina Macula Institute*

Signature: _____ Date_____

4201 Torrance Blvd., Suite 220,
Torrance, CA 90503
Phone: (310) 944-9393
Fax: (310) 944-3393

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RETINA MACULA INSTITUTE

RON P. GALLEMORE, M.D., PH.D.

# INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

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 your ophthalmologist 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 the doctors of Retina Macula Institute and/or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

| | |
|---|---|
| Patient or Patient's Representative Signature | Date |
| Print Patient's Name | Date |
| Physician's Authorized Representative's Signature | Date |

RETINA MACULA INSTITUTE

**Ron P. Gallemore, .M.D., Ph.D., Inc.**

***PATIENT REGISTRATION***

Last Name: _____First Name: _____ M.I. _____

Address: _____City: _____State: _____ ZIP _____

Home Phone: _____Cell Phone: _____Work: _____Email: _____

SS#: _____Date Of Birth_____ Sex: ___ Marital Status: Married ___Divorced ___Single ___Widowed ___

Employer Address: _____ Phone:_____

Emergency Contact: _____Relationship: _____Phone: _____

If patient is a minor, Parent/Guardian's Name: _____Phone:_____

***PHYSICAN INFORMATION:***

Referring Doctor: _____Phone: _____

Internist / Primary Care Physician:
_____Phone:_____

Eye Care Provider: (e.g. optometrist, general ophthalmologist, etc.)

_____Phone: _____

***PRIMARY INSURANCE INFORMATION:***

Primary Insurance: _____Policy ID #:_____Group #:_____

If Patient Is Not The Subscriber:

Name: _____ Date of Birth: _____SS#_____

Employer: _____Employer Phone: _____

Address: _____Occupation: _____

***SECONDARY INSURANCE INFORMATION:***

Secondary Insurance: _____Policy ID #: _____Group #:_____

If Patient Is Not The Subscriber:

Name: _____ Date of Birth: _____SS#_____

Employer: _____Employer Phone: _____

Address: _____Occupation: _____

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorized my physician to submit claims for benefits, for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I hereby authorize my Insurance Company to pay and hereby assign directly to **Ron P. Gallemore, M.D., Ph.D**., all benefits, if any otherwise payable to me for the services described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid for by **Ron P. Gallemore, M.D., PH.D**., will be credited to my account, in accordance with the above said signature.

Signature: _____Print Name: _____Date:_____


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**Your Rights.** Following is a statement of your right with respect to your protected health information.
**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied 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.

**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 purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
**You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed accept this notice alternatively, i.e. electronically.

**You may have the right to your physician amend your protected health information**. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain we have made, if any of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the State of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name: _____Signature:_____Date:_____

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## Physician – Patient Arbitration Agreement

Article 1:
Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical Service's rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2:
All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3:
Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4:
General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5:
Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6:
Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services: _____
(Patient's or Patient Representative's Initials)

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient or Patient's Representative Signature Date

By: _____ _____
Print Patient's Name Date

By: _____ _____
Physician's Authorized Representative's Signature Date

Ron P. Gallemore, MD., PH.D
Retina Macula Institute
4201 Torrance Blvd., Ste., 220, Torrance, CA 90503

RETINA MACULA INSTITUTE

# Patient Responsibility Disclosure Statement

Your signature below forms a binding agreement between Retina Macula Institute (the provider of medical services) and the patient receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The responsible party is the individual who is financially responsible for payment of medical bills.

Please Read and Sign Below:

**Co-Pays and Deductibles:** All co-payments, deductibles, and past due balances are due at the time of service. If your insurance company does not cover costs after your claim has been filed, then you will be responsible for payment and billed for it. Depending on your insurance carrier, Retina Macula Institute will collect the specialist co-payment.

**HMO plans:** If your insurance plan is a HMO, then you understand that an authorization from your primary care physician may be required for your insurance company to cover services provided by Retina Macula Institute. You agree to contact your primary care physician to obtain authorization prior to your visit today. If an authorization is not secured or your plan denies coverage, then you agree to assume responsibility for the charges accrued.

**Out-Of-Network Plans:** You acknowledge that it is your responsibility to verify and determine if Retina Macula Institute is in-network or out-of-network with your insurance plan. You understand that you are fully responsible for payment for any non-covered services.

**Patient Refunds:** Any refunds will be kept as a credit on your account unless you initiate a request. The following criteria must be met prior to issuing a patient refund:

1) You do not have any outstanding insurance claims.
2) You do not have any outstanding balances on your account.

By signing below, you are agreeing with the terms above,

_____ _____

Patient/Guardian Signature Date

RETINA MACULA INSTITUTE

**Ron P. Gallemore, .M.D., Ph.D., Inc.**

**PATIENT CONTACT INFO / RESTRICTIONS**

In general the HIPPA privacy rule gives individual the right to request a restriction on uses and disclosures of their protected information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home. I wish to be contacted in the following manner (check all that applies):

____ **Home Phone**: _____

____ Okay to leave message with detailed information

____ Leave message with name and call back number only

____ **Cell Phone**: _____

____ Okay to leave message with detailed information

____ Leave message with name and call back number only

____ **Written Communication**

____Okay to mail to my home address

____ Okay to fax #_____

____ E-mail _____

I hereby consent to the release of PHI to the following individuals, without the individual name, information will NOT be released. I understand this authorization will be in effect until revoked.

Name_____Relationship_____PHONE #_____

Name_____Relationship_____PHONE #_____

Name_____Relationship_____PHONE #_____

Name_____Relationship_____PHONE #_____

Patient Signature:_____ Date:_____

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# Medication Record

Name: _____ Last Name: _____

Date of Birth_____ Date: _____

**Please include prescription medication, vitamins, supplements and over the counter.**

**Name of medication, dose, and times**.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____
_____

**Allergies to Medication and Food:** **Reaction:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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# Review of Systems

## Eyes

| | | |
|---|---|---|
| Previous surgery | ☐ Yes | ☐ No |
| Contact Lens | ☐ Yes | ☐ No |
| Pain | ☐ Yes | ☐ No |
| Double Vision | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No |
| Macular Degeneration | ☐ Yes | ☐ No |
| Dry Eyes | ☐ Yes | ☐ No |
| Flashes | ☐ Yes | ☐ No |
| Floaters | ☐ Yes | ☐ No |

## Ear, Nose, and Throat

| | | |
|---|---|---|
| Hard of Hearing | ☐ Yes | ☐ No |
| Ringing in Ears | ☐ Yes | ☐ No |
| Vertigo | ☐ Yes | ☐ No |

## Cardiovascular

| | | |
|---|---|---|
| Chest Pain | ☐ Yes | ☐ No |
| Dizziness | ☐ Yes | ☐ No |
| Fainting Spells | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |
| Irregular Heart Beat | ☐ Yes | ☐ No |
| Difficulty Lying Flat | ☐ Yes | ☐ No |

## Constitutional

| | | |
|---|---|---|
| Fatigue/Weakness | ☐ Yes | ☐ No |
| Fever | ☐ Yes | ☐ No |
| Weight Gain/Loss | ☐ Yes | ☐ No |

## Respiratory

| | | |
|---|---|---|
| Cough | ☐ Yes | ☐ No |
| Congestion | ☐ Yes | ☐ No |
| Wheezing | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |

## Gastrointestinal

| | | |
|---|---|---|
| Heartburn | ☐ Yes | ☐ No |
| Nausea/Vomiting | ☐ Yes | ☐ No |
| Jaundice/Hepatitis | ☐ Yes | ☐ No |

## Genito-Urinary

| | | |
|---|---|---|
| Pain/Difficulty | ☐ Yes | ☐ No |
| Blood in Urine | ☐ Yes | ☐ No |
| History of Kidney Stones | ☐ Yes | ☐ No |
| History of STDs | ☐ Yes | ☐ No |

## Psychiatric

| | | |
|---|---|---|
| Anxiety/Depression | ☐ Yes | ☐ No |
| Mood Swings | ☐ Yes | ☐ No |
| Difficulty Sleeping | ☐ Yes | ☐ No |

## Endocrine

| | | |
|---|---|---|
| Increased Thirst | ☐ Yes | ☐ No |
| Increased Hunger | ☐ Yes | ☐ No |
| Increased Sweating | ☐ Yes | ☐ No |
| Fingernail Changes | ☐ Yes | ☐ No |

## Blood/Lymph Nodes

| | | |
|---|---|---|
| Easy Bruising | ☐ Yes | ☐ No |
| Gums Bleed Easily | ☐ Yes | ☐ No |
| Prolonged Bleeding | ☐ Yes | ☐ No |
| Heavy Aspirin Use | ☐ Yes | ☐ No |

## Musculoskeletal

| | | |
|---|---|---|
| Stiffness | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No |
| Joint Pain/Swelling | ☐ Yes | ☐ No |

## Neurological

| | | |
|---|---|---|
| Seizures | ☐ Yes | ☐ No |
| Weakness/Paralysis | ☐ Yes | ☐ No |
| Numbness | ☐ Yes | ☐ No |
| Tremors | ☐ Yes | ☐ No |

## Immunologic

| | | |
|---|---|---|
| Hives | ☐ Yes | ☐ No |
| Itching | ☐ Yes | ☐ No |
| Runny Nose | ☐ Yes | ☐ No |
| Sinus Pressure | ☐ Yes | ☐ No |

_____ _____

Patient Signature Date

# THINGS TO BRING TO YOUR APPOINTMENT

**CO-PAY FOR VISIT**

**DRIVER**

**INSURANCE CARD(S)**

**ID (DRIVER LICENSE)**

**SUNGLASSES**

**MEDICATION LIST OR MEDICATIONS**

**CONSULT REQUEST FORM (IF GIVEN TO YOU)**

**AUTHORIZATION FROM PCP OFFICE**

**SNACK IF YOU ARE DIABETIC**

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