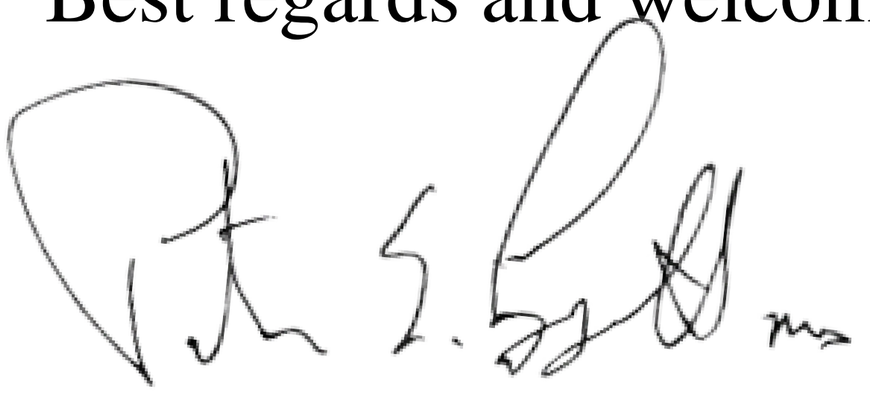
HILTON HEAD
MACULA & RETINA
Peter E. Liggett, MD

Dear New Patient:

Welcome to our practice. We will do our utmost to help you with your eye problem. Our office is equipped with the most advanced digital imaging equipment and laser treatment systems available for diagnosis and treatment of macula and retina problems. Dr. Liggett has more than 30 years of experience and uses the most cutting edge therapies available.

We are asking new patients to fill out a fairly involved history form. Most of the questions are to help us help you, but there are some questions that the government and/or insurance companies require us to ask.

Best regards and welcome,



Peter E. Liggett, MD

15A Lafayette Place | Hilton Head Island, SC 29926 | 843-422-9987 | FAX 843-715-3308 | www.hhmr.org

HILTON HEAD
MACULA & RETINA
Peter E. Liggett, MD

15 Lafayette Place Suite A
Hilton Head, SC 299262277
ph: (843) 422-9987 fx: (843) 715-3308

Patient Demographics

First Name_____ Middle Name_____ Last Name_____

Date of Birth_____ Social Security: _____ How did you hear about us? _____

Address _____

City _____ State _____ Zip Code_____ Would you like appointment reminder calls? ☐ Yes ☐ No

Do you have a caregiver or Medical Power of Attorney? _____

Please list the phone numbers and email where we can reach you:

	Phone Number/ Email	Preferred method of contact	OK to leave message?
Cell Phone		☐	Yes ☐ No ☐
Home Phone		☐	Yes ☐ No ☐
Work Phone		☐	Yes ☐ No ☐
Other		☐	Yes ☐ No ☐
Email		☐	Yes ☐ No ☐

Please list any other contacts we can speak to in case of emergency or regarding your health:

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____

Authorized Medical Info Contact: _____ Relationship: _____ Phone: (_____)_____

Referring Physician: _____ Phone: (_____)_____

Primary Care Provider: _____ Phone: (_____)_____

Other Providers: _____ Phone: (_____)_____

Preferred Pharmacy: _____ Occupation (current or former): _____

Which category best describes your race?	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Decline	Tobacco Use: (Choose one only)	☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐ Heavy tobacco smoker ☐ Light tobacco smoker Date Started: _____ Date Ended: _____
Do you consider yourself Hispanic/Latino?	☐ Yes ☐ No ☐ Decline		
What is your primary language?			

_____ _____

Patient or Legal Guardian Signature **Date**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____

Date: _____ Height: _____ Weight: _____ Gender: ☐ Male ☐ Female

How did you hear about us? _____

Ethnic Background: _____ Reason for visit today: _____

Primary Eye Doctor: _____ Primary Care Doctor: _____

Preferred Pharmacy: _____

Do you have or have you had:	☐ Loss of vision ☐ Cataracts ☐ Macular Degeneration ☐ Blurry Vision ☐ Glaucoma ☐ Double Vision ☐ Distorted Vision ☐ Detached Retina ☐ Loss of Color Vision ☐ Floaters ☐ Blindness ☐ Loss of Night VIsion ☐ Flashes ☐ Lazy Eye ☐ Glasses/Contacts ☐ Eye Pain ☐ Eye Injury ☐ Myopia (near sightedness) ☐ Eye Redness ☐ Cornea Problems
Other EYE Problems:	
EYE DROPS you are taking:	
EYE SURGERIES:	Surgery Date
Food or Drug ALLERGIES:	Substance Reaction

MEDICAL HISTORY QUESTIONNAIRE

Medications you have taken in the last 60 days:

(If you gave a MEDICATION LIST, please give to receptionist to copy in lieu of filling out form.)

Medication	**Dosage**	**Frequency** (PRN = as needed)	**Reason for taking**

Surgical History

Procedure	**Date**

MEDICAL HISTORY QUESTIONNAIRE

Personal History *(Please include dates if possible.)*

Diabetes	☐ YES ☐ NO	Date of diagnosis: Fasting blood sugar this morning:	Most recent A1c and Date Taken:
Cancer	☐ YES ☐ NO	Type:	Date of diagnosis:
Hypertension	☐ YES ☐ NO		
High Cholesterol	☐ YES ☐ NO		
Heart Attack	☐ YES ☐ NO		Date:
Stroke	☐ YES ☐ NO		Date:
Autoimmune Disorders	☐ Rheumatoid arthritis ☐ Lupus ☐ Sjogren's ☐ Psoriasis ☐ Celiac Disease ☐ Ulcerative colitis ☐ Multiple Sclerosis ☐ Pernicious anemia ☐ Other_____		
Occupation (or previous)			
Marital Status	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed		
Tobacco Use	☐ None ☐ Current Smoker (# packs per day) ☐ Former Smoker Quit date:		
Alcohol Intake	☐ None ☐ Rarely ☐ Daily ☐ Weekly ☐ 1-2 drinks ☐ 2-4 drinks ☐ Other_____		
Substance abuse	☐ None ☐ Cannabis ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other_____		

Family History

Macular Degeneration	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather	☐ Sister ☐ Brother
Retinal Disorders (please specify)	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather	☐ Sister ☐ Brother _____
Cataracts	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather	☐ Sister ☐ Brother
Glaucoma	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather	☐ Sister ☐ Brother
Other Eye problems					
Immediate family with these diseases?	☐ Diabetes	☐ Heart Disease	☐ Stroke	☐ Cancer	
Is mother deceased?	☐ YES	☐ NO	Cause of death:		Age:
Is father deceased?	☐ YES	☐ NO	Cause of death:		Age:
Is sibling deceased?	☐ YES	☐ NO	Cause of death:		Age:

MEDICAL HISTORY QUESTIONNAIRE

Systems	Fill in any current problems
Heart/Vascular	
Respiratory	
Intestinal Tract	
Urinary Tract	
Muscle/joints	
Skin	
Brain/nerves	
Psychiatric	
Endocrine	
Hematology	
Allergy/Immune	

Vaccinations: **Date:**

Flu: ☐ YES ☐ NO _____

Covid: ☐ YES ☐ NO _____

Pneumonia: ☐ YES ☐ NO _____

Previous health care visits in last 3 months:

Reason Date Treatment Results

_____

_____

_____

Hospitalizations in last 3 months:

Reason Date Treatment Results

_____

_____

_____

Patient Signature: _____

Date: _____

Hilton Head Macula & Retina

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclose in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, ueses and disclosures of PHI for marketing purposes, and disclose that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Healthcare Operations. We may use and disclose medical information about you for health care operations. These users and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect ot medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide a reason that supports your request. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specific how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer, (843)422-9987, 15A Lafayette Place, Hilton Head Island, SC 29926. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice, or would like to receive a more detailed explanation, please contact our Privacy Officer.

HIPAA Compliance Notice: I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read, and understand and consent to the use and disclosure of protected health information above myself for treatment, payment, and health care operations.

Release of Records for Insurance: I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Hilton Head Macula & Retina.

No Show Policy: If you are unable to keep your appointment, please notify us 24 hours in advance of your scheduled appointment. Failure to provide such notice may result in a $50.00 no-show fee.

Financial Policy: I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Hilton Head Macula & Retina, and be applied to my account for services rendered. Your contract for health insurance is between you and your insurance company. We are not party to that contract. It is ultimately your responsibility to see that your bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is (if any) and yours. It is also your responsibility to determine if Hilton Head Macula & Retina is a participating provider. Any unpaid money by your insurance company will be your responsibility. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. ***I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. If I am uninsured I am aware that I am financially responsible for all payments incurred.*** If payment for services is not entirely paid within 30 days from the date of service, a later fee of 10% of the outstanding amount plus interest equal to 1.5% per month of the unpaid balance 18% annual percentage) rate will be added to the unpaid balance. I am aware there may be additional collection and/or attorney's fees and expenses if my account is referred for collection. For patients cover by Medicare, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Hilton Head Macula & Retina

<u>Agreement for evaluation and treatment by Doctor Liggett:</u> I agree to let Dr. Liggett evaluate and treat my eye condition.

By signing below, you acknowledge and agree to policies and procedures stated above.

_____ _____

Signature of Patient or Patient's Representative **Date**

<u>Addendum: Emergency Patients and Out of Area Patients:</u>

We are happy to help you with your problem. **<u>There are dozens of indivudal insurance plans provided by each insurance company.</u>** While we may be listed on your insurance company, **<u>we may not be listed on your individual plan.</u>** There is no way to verify if we are in network with your plan within 48 hours. It is your responsibility to determine if we are a participating provider in your insurance program. We sugest you call the number on the back of your insurance card now and give the insurance company **<u>Dr. Liggett's NPI numbers (1396775326 ir 1255767703)</u>** to see if you will be covered for your visit and any treatment. **<u>It is ultimately your responsibility to see that your bill is paid in full.</u>**

An initial Emergency visit is $500 which includes all evaluation, diagnosis and digital imaging (required for evaluation) but does not include any treatment that may be required.

I understand that I am responsible for any bills not paid by my insurance carrier.

_____ _____

Signature of Patient or Patient's Representative **Date**