RETINA CONSULTANTS
OF HAWAII

Gregg T. Kokame, MD · James C. Lai, MD · Sarah P. Read, MD, PhD · Raymond Wee, MD

Eye Physician and Surgeon
Diseases and Surgery of the Retina, Macula and Vitreous

Pali Momi Physicians Building
98-1079 Moanalua Rd.
Suite 470
Aiea, HI 96701

Kuakini Medical Plaza
321 N. Kuakini St.
Suite 307
Honolulu, HI 96817

Hale Pawa'a
1401 S. Berentania St.
Suite 340
Honolulu, HI 96814

Kauai Offices
4439 Pahe'e St. /4418 Kukui Grove
Lihue, HI 96766

Maui Office
33 Lono Ave #260
Kahului, HI 96766

Dear Patient:

Physicians have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently issued regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers, and health plans.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to your health plan, your physician, the hospital, other health care provider or health plan will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as email) are protected by the privacy rule.

The privacy rule also provides you with certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy officer about exercising your rights with regard to your confidential health information.

Please let us know if you have any questions about our Notice of Uses and Disclosures of Protected Health Information. You may contact our privacy officer Selina Mattos, or discuss any questions you may have with your physician.

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and related to your past, present, or future physical or mental health or condition, the provision of health care services to you, or the present, past, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment.

2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management, or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your Protected Health Information in connection with treatment, payment, or health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety, or effectiveness of FDA-related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; (h) for selected governmental functions such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.

2. The right to request in writing and to receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).

3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment, and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Selina Mattos, who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Selina Mattos at 487-8928.

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PATIENT INFORMATION SHEET
(Please Print Clearly)

Name:_____ Sex: ☐M ☐F Birthdate: ____/____/_____
Last First MI

Marital Status: ☐Married ☐Single ☐Widowed Soc. Sec. #:_____

Mailing Address: _____ Email Address: _____

City, State, Zip: _____ Primary Care Doctor: _____

Referred By: _____

Home Phone #: _____

Cell#:_____ Occupation: _____

Business Phone #: _____ Employer: _____

Responsible Party: _____ Phone#: _____

Relationship:_____

Emergency contact: _____ Phone#: _____

Relationship:_____

Primary Insurance:_____ Subscriber: _____

Subscriber No.: _____ Relationship: _____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber No.: _____ Relationship:_____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber No.: _____ Relationship: _____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

I hereby authorize Retina Consultants of Hawaii to release all medical information regarding my illness, care and/or injury to my insurance carriers, any health care facility, and any other physician that would benefit my health care. I hereby assign to Retina Consultants of Hawaii all payment to which I am entitled for medical/surgical expenses related to the service reported from the above.

I hereby authorize Retina Consultants of Hawaii to take photographs of my eyes for the sole purpose of research, education, and journal publication. I understand that these photographs will be anonymized and will not contain any of my personal information

I understand I am financially responsible to Retina Consultants of Hawaii for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is as valid as the original.

Date: _____ Signature: _____
(Parent or Guardian if minor)

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REVIEW OF SYSTEMS (ROS-PFSH)

PATIENT NAME:_____ **DATE:** _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR MEDICAL HEALTH HISTORY:

Who referred you here today? Name:_____ Phone:_____
Address: _____

Which pharmacy do you use? Name:_____ Phone:_____
Location: _____

Who are your medical doctors?

Name:	Specialty:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

What eye problems have you had in the past?

Cataract Surgery:	☐ RT Eye	☐ LT Eye	M.D._____ Date_____
Glaucoma:	☐ RT Eye	☐ LT Eye	Prior Treatment: _____
Macular Degeneration:	☐ RT Eye	☐ LT Eye	Prior Treatment: _____
Diabetic Retinopathy:	☐ RT Eye	☐ LT Eye	Prior Treatment: _____

Other: _____

Eye Medications? (which eye, name, strength, dosage)

_____
_____
_____

What other surgeries (non-eye related) and hospitalizations have you had?

1) _____ Year:_____ M.D./Hospital:_____
2) _____ Year:_____ M.D./Hospital:_____
3) _____ Year:_____ M.D./Hospital:_____
4) _____ Year:_____ M.D./Hospital:_____

What medications/supplements are you on? (name, strength, dosage, frequency, indication)

_____
_____
_____
_____

Allergies/Reaction: _____ Latex Allergy? ◉ Yes ○ No

Have you received your pneumococcal vaccine? ◉ Yes ○ No

Have you received your influenza immunization this year? ◉ Yes ○ No

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REVIEW OF SYSTEMS & PAST MEDICAL

PATIENT NAME: _____

*****PLEASE CHECK ANY PROBLEM AREA AND EXPLAIN IN DETAIL. CHECK "NO" IF YOU HAVE NOT HAD ANY PROBLEMS:**

EARS, NOSE, MOUTH, THROAT

Yes	No	
☐	☐	hearing loss _____
☐	☐	sinus problems _____
☐	☐	sleep apnea _____
☐	☐	other _____

HEART & BLOOD VESSELS (cardiovascular)

☐	☐	heart attack _____
		date: _____
☐	☐	high blood pressure _____
		onset date: _____
☐	☐	heart murmur _____
☐	☐	irregular heart beat _____
☐	☐	mitral valve prolapse _____
☐	☐	atrial fibrillation _____
☐	☐	other _____

LUNGS (respiratory)

☐	☐	asthma _____
☐	☐	bronchitis _____
☐	☐	shortness of breath _____
☐	☐	emphysema _____
☐	☐	Tuberculosis _____
☐	☐	COPD _____
☐	☐	other _____

STOMACH & INTESTINES (gastrointestinal)

☐	☐	ulcers _____
☐	☐	diverticulitis _____
☐	☐	constipation _____
☐	☐	hepatitis _____
☐	☐	other _____

KIDNEYS, BLADDER, PROSTATE (genitourinary)

☐	☐	kidney failure _____
☐	☐	kidney dialysis _____
☐	☐	dialysis schedule _____
☐	☐	urinary infections _____
☐	☐	hepatitis _____
☐	☐	other _____

CANCER

☐	☐	type _____
		onset date: _____
		treatment _____

BONES, JOINTS, MUSCLES (musculoskeletal)

Yes	No	
☐	☐	osteoporosis _____
☐	☐	arthritis _____
		type _____
☐	☐	other _____

ENDOCRINE SYSTEM

☐	☐	diabetes _____
		onset date: _____
		recent HbA1c: _____
		date of HbA1c: _____
☐	☐	insulin _____ last blood sugar: _____
☐	☐	thyroid _____
☐	☐	high cholesterol _____
☐	☐	other _____

NERVOUS SYSTEM (neurological)

☐	☐	stroke _____
		date: _____
☐	☐	seizures _____
☐	☐	migraines _____
☐	☐	dementia _____
☐	☐	Alzheimer's _____
☐	☐	paralysis/weakness _____
☐	☐	other _____

SKIN/BREAST (integumentary)

☐	☐	keloid, scarring _____
☐	☐	eczema _____
☐	☐	psoriasis _____
☐	☐	other _____

BLOOD (hematological/lymphatic)

☐	☐	anemia _____
☐	☐	excessive bleeding _____
☐	☐	clotting problems _____
☐	☐	other _____

ALLERGIC/IMMUNOLOGIC

☐	☐	lupus _____
☐	☐	HIV _____
☐	☐	other _____

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SOCIAL & FAMILY HISTORY

PATIENT NAME: _____

SOCIAL HISTORY:

What is your occupation? _____
Do you currently drive? ◯ Yes ◯ No
Living condition? ◯ Alone ◯ With Family ◯ Carehome/Caretaker
Do you smoke cigarettes? _____ How many per day? _____ How many years? _____
Do you drink alcohol? _____ How much? _____ How frequently? _____
Have you ever lived outside of Hawaii? _____ If yes, where? _____
Past and present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this: ◯ Yes ◯ No ◯ N/A
Have you ever had a blood transfusion since 1977? ◯ Yes ◯ No ◯ N/A

FAMILY MEDICAL HISTORY:

Have any of you family (parents, siblings, relative, ancestors) had any of the following medical problems? Please check "yes" or "no" for each problem and list who had that condition:

Yes	No		Yes	No	
☐	☐	Diabetes _____	☐	☐	Tuberculosis _____
☐	☐	Thyroid disease _____	☐	☐	Heart Disease _____
☐	☐	Stroke _____	☐	☐	High Blood Pressure _____
☐	☐	Anemia _____	☐	☐	Kidney disease _____
☐	☐	Hepatitis _____	☐	☐	Bleeding disease _____
☐	☐	Cancer (type) _____	☐	☐	Other _____

FAMILY EYE HISTORY:

Have any members of your family had any of the following eye problems:

Yes	No		Yes	No	
☐	☐	Retinal Detachment _____	☐	☐	Glaucoma _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Retinitis Pigmentosa _____
☐	☐	Macular Degeneration _____	☐	☐	Other _____

RACE* *(*Optional to Answer)*

☐ White ☐ Black or African American
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Asian; (specify): _____
☐ Other (specify): _____

EYE COLOR*

☐ Blue ☐ Brown ☐ Green
☐ Grey ☐ Hazel ☐ Other: _____

Is there anything not mentioned on this form that you would like the doctors to be aware of?

Your eyes will be dilated for your exam. Dilation will make the pupils of your eyes large for several hours and can cause *light sensitivity*, *glare*, and *blurred vision*. Dark glasses are recommended. If you do not have your own, please ask us for a pair.

Patient's Signature: _____ Date: _____

M.D. initials: _____

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PATIENT RECORD OF DISCLOSURES
and
Acknowledgement of Receipt of Notice of Uses and Disclosures of Protected Health Information for
Retina Consultants of Hawaii

In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from the receptionist. I hereby acknowledge that I received from Retina Consultants of Hawaii a copy of the Notice.

I wish to be contacted in the following manner (check all that apply):

Home Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number

Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

_____

Work Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number

☐ Other: _____

_____ _____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate