RAJ K. MATURI, M.D., P.C.
Vitreoretinal Disease and Surgery
www.indyretina.com
200 West 103rd Street, Suite 1060
Indianapolis, Indiana 46290
Direct Line: 317-817-1414
Answered 24 hours: 317-817-1000

Dear Prospective Patient:

Welcome to our practice. This letter will provide you with information about your upcoming appointment with Raj Maturi, MD at

☐ CARMEL	☐ GREENWOOD	☐ KOKOMO
200 W 103rd St. Indpls, IN 46290	555 E County Line Rd Greenwood, IN 46143	1601 W Lincoln Rd Kokomo, IN 46902

This is a reminder that you have an appointment with

Dr. Raj K. Maturi, M.D., P.C.

ON _____ AT _____

- **We ask that you allow approximately three hours (3 hours) for your initial visit as well as for possible diagnostic testing. Diabetic patients should adjust their meal schedules accordingly and bring along a snack.**
- During your examination, you will undergo dilation of both pupils. Dilation can make your eyes extremely sensitive to sunlight and glare. **We recommend that you have someone accompany you to your appointment and drive you home. If you live in a nursing home, a nurse from there will have to accompany you for your ENTIRE visit.**
- In order to save you time, please complete the enclosed forms at home. **Please bring these forms as well as your insurance card(s) to your appointment.** The following forms are included with this letter:

1. Two-sided patient information form.
2. Single-sided page of authorizations for patients with Medicare coverage. Medicare guidelines require all Medicare patients to complete this form.
3. Four-page medical history questionnaire. It is very important to list **all medications, vitamins and herbal supplements that you take**, because some may affect your vision.

Dr. Maturi is certified by the American Board of Ophthalmology and has received additional training in diseases of the retina and vitreous. If your physician has referred you for further consultation regarding your retinal problems, Dr. Maturi will send your physician a complete report of findings and recommendations. While you are here for your consultation, Dr. Maturi will discuss your condition with you and answer any questions you have regarding your retinal problems.

FINANCIAL INFORMATION

The following information has been provided to answer your questions regarding insurance coverage and our established reimbursement policies.

- **If you have a Managed Care (HMO) insurance plan, please contact the member services phone number listed on your insurance card to confirm Dr. Maturi's participation with your insurance network.**

- If you participate in a Managed Care (HMO) insurance plan, **you are required to obtain authorization for your visit with Dr. Maturi**. If you are uncertain whether this applies to you, please contact the member services phone number listed on your insurance card.

  If your insurance requires a written or formal referral **<u>you are required</u>** to contact your Primary Care Physician (PCP) to start the referral process. Please ask the PCP to fax a copy to 317-805-4587 confirming your referral is complete. You may call our office directly at 317-817-1414 to confirm that we have received the referral information. If you need to check the status of your referral please call your PCP.

- Many insurance plans require a **co-payment that is due at the time of service**. If you are a **self-pay** patient or with **insurance that Dr. Maturi is out of network, payment for that visit is due at that time of service. We encourage you to have at least four hundred dollars ($450) with you at time of service.**

- We do accept Visa, MasterCard and Discover, as well as cash and checks. You will be given a receipt.

- **If your insurance changes, please give us your new insurance information prior to your return visit.**

We look forward to meeting you. A map has been included with this letter for your convenience**. We ask that you refrain from wearing make-up or perfume to your appointment**. If you are going to be late for your appointment, please telephone before you come, because we might need to reschedule your appointment. If you must cancel or reschedule your appointment, please call at least 24 hours in advance, as this will allow another patient to use this time. If you have any questions, please call our main office in Indianapolis at 317-817-1414 or 866-700-3937 (toll-free).

PATIENT REGISTRATION FORM

RAJ K. MATURI, MD, PC

Date:_____

Patient Name:_____
Last First Middle

Date of Birth: _____ Age: _____ Sex:_____Social Security:_____

Address: _____
Street City, State Zip

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor Child

*If patient is a minor, lives with:*_____*Relationship:* _____

Patient or Parent

□ Employed *Occupation*_____

□ Retired □ Full Time Student □ Part Time Student □ Disabled □ Unemployed

Employer Name and Address: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Social Security: _____

Spouse's Employer and Address:_____

Primary Insurance Holder/Responsible Party

Name: _____ Relationship to Patient: _____

Address, if other than same: _____

Home Phone: _____Work Phone: _____

Birth date: _____Social Security: _____

Employer Name and Address: _____

MIDWEST EYE INSTITUTE

PATIENTS NAME: _____

Emergency Contact/Nearest Friend/Relative Not Living With You

Name: _____

Relationship to Patient: _____

Address, if other than same: _____

Phone: _____ Alternate Phone: _____

Referring Physician/Medical Insurance Information

Name of Referring Physician: _____ Phone #: _____

Name of Family of Primary Care Physician: _____ Phone #: _____

Physician Address: _____

Do you have medical insurance to cover your examination or treatment?

☐ Yes ☐ No

If yes, we will take a copy of your insurance cards. *If you do not have an insurance card, please indicate insurance carrier name and you I.D. #* _____

Does your insurance company require a formal authorization or referral for exam or treatment from a Primary Care Physician?

☐ Yes ☐ No

If Yes, Physician's Name: _____

Accident Information

COMPLETE IF YOUR TREATMENT IS FOR AN INJURY OR ACCIDENT

Were you injured at work? ☐ Yes ☐ No

Is this covered by Workman's Compensation? _____

If Yes, Contact Person at your Employer: _____

Date & Time of Accident: _____ Place of Accident: _____

How did injury happen? _____

_____

Name of Physician who treated you at time of accident: _____

MIDWEST EYE INSTITUTE

PATIENTS NAME: _____

Financial Responsibility Statement/Release of Information Authorization

I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Physician for services received. I also authorize the release of information to the listed physicians and or individuals. I understand that this authorization remains valid unless/until I revoke it myself.

X_____ Date: _____
Signature of Patient or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.

X_____ Date: _____
Signature of Patient or Legal Guardian

Photography Release

I consent that photographs may be taken in connection with the medical services I receive. I understand that such photographs shall be used in my medical record and may be shared with others, including but not limited to, my insurance carrier. I also give permission for these photographs and information relative to them and/or relating to my case to be published for the purposes of medical research, education or science; and I specify that any such publication of these photographs will not include my name. I understand that this release remains valid unless/until I revoke it myself.

X_____ Date: _____
Signature of Patient or Legal Guardian

MIDWEST EYE INSTITUTE

PATIENTS NAME: _____

Patients Medicare Authorization
ONLY to be signed by patients who are covered by Medicare

Patients Name: _____

Patients Medicare Number: _____

I request that payment of authorized Medicare Benefits be made either or on my behalf to Raj K. Maturi, M.D., P.C. for any services furnished to me by that physician/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

Patient's Signature: _____

Date: _____

Patients Additional or Supplemental Authorization

Patient Name: _____

Patient's Policy/Member Number: _____

I request that payment of authorized benefits be made to either or on my behalf to Raj K. Maturi, M.D., P.C. for any services furnished to me by that physician/supplier. I authorize any holder or medical information about me to release _____ (company) any information needed to determine these benefits or the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

Patient's Signature: _____

Date: _____

MIDWEST EYE INSTITUTE

PATIENTS NAME: _____

A Statement to Midwest Eye Institute Patients Regarding Dilation of Your Eyes

We would like to inform our patients that it may be necessary during the course of your exam to dilate your eyes with drops. In some people, the dilating drops cause blurred vision, light sensitivity, and inability to read. These problems go away as the effects of the drops wear off. You should be careful walking, going up and down stairs, and should not drive a car. In very rare cases, the drops may cause elevated eye pressure requiring further treatment.

It is for this reason that we recommend someone comes with you at the time of your exam as a driver. Also, for your comfort, you may obtain dark glasses or inserts for your glasses at the reception desk.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye examination.

Signature of Patient/Guardian: _____

Date: _____

PATIENTS NAME: _____

Midwest Eye Institute
Notice of Privacy Practices

As out patient, we are offering you a copy of
Midwest Eye Institute's
Notice of Privacy Practices to retain for your information/reference. Copies are also available at any time from our reception desk, or directly from the doctor's office. You are welcome to review or have a copy of this notice at anytime upon request.

Complaints/Comments

If you have any comments, questions, or complaints concerning our privacy practices, you may also contact the Secretary of the Department of Health and Human Resources, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington, D.C. 20201 (E-mail: ocrmail@hhs.gov).

You will not be retaliated against or penalized by us for making an inquiry or filing a complaint.

To obtain more information concerning this notice, you may contact our Privacy Officer:

Barbara Bernhard, Executive Director
Midwest Eye Institute, P.C.
200 West 103rd Street, Suite 1000
Indianapolis, Indiana 46290
Attn: Patient Privacy Request

Signature Required

Your signature is required below indicating that the entirety of the Midwest Eye Institute Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you as well. A copy of this signature page will be maintained in your medical chart, and can also be given to you upon request.

_____ _____
Patient Signature Date

_____
Patient Name – PRINTED

This Notice of Privacy Practices is effective April 1, 2003.

PATIENTS NAME: _____

Midwest Eye Institute
Authorization for RELEASE or USE and DISCLOSURE of PROTECTED HEALTH INFORMATION

Dear Patient,

This form is OPTIONAL. It is to be used in the event that either the patient or the treating physician has a specific desire or need to release all or any portion of a patient's protected health information (PHI) to any persons or organizations not already involved with the patients care. IF YOU DO NOT WISH TO HAVE ANY OF YOUR MEDICAL INFORMATION SHARED with anyone other than the physician that referred you to Midwest Eye Institute, YOU DO NOT NEED TO COMPLETE THIS FORM.

This form is included with a new patient's paperwork in order to provide an opportunity for a patient to provide their authorization for the Midwest Eye treating physician to share their PHI to a guardian, other family members, or even non-referring physicians.

This form should NOT be completed unless the patient agrees to a PHI release. If no Additional release of the patient's PHI is require, this form is NOT required.

Patient Name: _____ DOB: _____
Please Print

Name of Midwest Eye Institute Physician: Raj K. Maturi, M.D., P.C.

Name of Person(s) and or Organization who is being authorized to receive information (include anyone you want to have information about the treatment you receive at Midwest Eye Institute)

_____
_____
_____
_____
_____

Limitations to this Authorization must be identified below. If this portion of the form is left blank, it is assumed that the information authorized for released is unrestricted.

Please describe below any restrictions you wish to place on this authorization. (Restrictions might include limitations as to type of information released; specific dates or period of time involved; or a specific purpose for which the release might apply)

_____
_____
_____
_____

PATIENTS NAME: _____

Midwest Eye Institute
Raj K Maturi, M.D., P.C.

As a patient I understand and accept the following statements:
I may see and copy the information described on this form if I ask for it, and I can receive a copy of this form after I sign it if I request one.

Patient Initials_____

If my physician has initiated this Authorization I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I will not be able to get that treatment without signing this form.

Patient Initials_____

I hereby authorize the release or use and disclosure of my individually identifiable health information (aka Protected Health Information or PHI) as described above. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice or Midwest Eye Institute the released information may no longer be protected by federal privacy regulations.

(NOTE: If a patient is unable to sign for themselves and is underage, or if there is a Medical Power of Attorney in effect, a legal guardian or the POA must sign this release Below as "PATIENT REPRESENTATIVE". If this Authorization has been initiated by anyone other than the patient, their legal guardian or the patients authorized representative, the patient may refuse to sign this Authorization.

_____ _____
Signature of patient, legal guardian or patient representative Date

Printed Name of Guardian or Representative:_____

As appropriate, describe guardian or representative's relationship to the patient:

_____

Witness:_____ Date:_____
(Witness is required if someone other than the patient is signing on behalf of the patient)

Expiration Date (Optional): Patient may set an expiration date for this Authorization
This authorization will expire on _____/____/_____ (DD/MM/YR) or on the occurrence of the following event:_____

Revocation (Optional): This authorization may be revoked at anytime by notifying your Midwest Eye Physician in writing:

Dr. Raj K Maturi, M.D., P.C.
C/O Midwest Eye Institute
200 West 103rd Street, Suite 1000
Indianapolis, Indiana 46290

If I, as a patient or patient representative, do revoke this authorization, I understand that action will not apply to activity that occurs before the Revocation is received.

Health Questionnaire

NAME _____ DATE _____

What eye problems are you currently having? _____

PAST **EYE** PROBLEMS AND **EYE** SURGERIES:

	YES	NO	DESCRIBE
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Cornea	☐	☐	_____
Retina	☐	☐	_____
Refractive Surgery	☐	☐	_____
Laser for Retina	☐	☐	_____
Laser for Cataract	☐	☐	_____
Other			_____

EYE DROPS:

Name	Dose/Which eye	Reason for using

PAST MEDICAL HISTORY (SIGNIFICANT HEALTH PROBLEMS)

	YES	NO	
Hypertension	☐	☐	HOW LONG?_____ Controlled?_____
Diabetes	☐	☐	HOW LONG?_____ Yrs.
			Yrs on Insulin _____Yrs on Pills _____
			Last Finger stick Blood sugar _____
Heart Disease	☐	☐	EXPLAIN_____
High Cholesterol	☐	☐	Last reading_____
Lung Disease	☐	☐	EXPLAIN_____
Cancer	☐	☐	EXPLAIN_____
Stroke	☐	☐	EXPLAIN_____

PAST SURGERIES (OTHER THAN EYE)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

REVIEW OF SYSTEMS

(Do you have any of the following? If yes, please circle problem.)

NAME _____ DATE _____

YES	NO	
☐	☐	**Constitutional**: chills, fever, fatigue, fever, loss of appetite, night sweats, weakness, weight loss/gain Explain_____
☐	☐	**Ear Nose Throat**: dry mouth, earaches, hearing loss, mass, mouth sores, nasal discharge, nosebleeds, sinus problems, smell disturbances, sore throat, tinnitus, vertigo Explain_____
☐	☐	**Cardiovascular**: chest pain, heart failure, heart attack, heart murmur, high blood pressure, irregular heart beat, palpitations, rheumatic fever, slow heart rate, swelling of feet Explain_____
☐	☐	**Respiratory**: asthma, bronchitis, chronic cough, emphysema, pneumonia, shortness of breath, spitting up of blood or mucous, tuberculosis, wheezing Explain_____
☐	☐	**Gastrointestinal**: abdominal pain, black tarry stools, change in bowel movements, constipation, diarrhea, heartburn, hemorrhoids, hepatitis, jaundice, loss of appetite, nausea, rectal bleeding, ulcers, vomiting, vomiting of blood Explain_____
☐	☐	**Genitourinary**: blood in urine, discharge, discomfort, frequent urination, hesitancy, impotency, infections, incontinence, kidney stones, pain, painful urination, prostate problems, polyuria, sexual dysfunction, sexually transmitted disease. Explain_____
		Have you ever had intimate contact with a person who may have been exposed or is infected with a sexually transmitted disease? _____ Treated? _____ If yes, when? _____Resolved? _____
☐	☐	**Musculoskeletal**: arthritis, arthritis distal joints, arthritis proximal joints, decreased range of motion, gout, joint pain, low back pain, muscle aches, muscle cramps, stiffness, swollen joints Explain_____
☐	☐	**Integumentary** skin/breast: breast cancer, dermatitis, dryness, eczema, hives, itching, loss of hair, masses, pigmented lesions, rashes, skin cancer, skin tumors. Explain: _____
☐	☐	**Neurological**: blackouts, headaches, memory loss, numbness, paralysis, strokes, migraines, seizures, tingling, tremors, weakness Explain _____
☐	☐	**Psychiatric**: anxiety, depression, hallucinations, nervousness Explain _____
☐	☐	**Endocrine**: cold intolerance, excessive hunger, excessive thirst, excessive urination, heat intolerance, hypoglycemia, thyroid problems Explain_____
☐	☐	**Hematologic/Lymphatic**: anemia, easy bleeding, easy bruising, swollen glands, unusual bleeding, blood clots Explain _____
☐	☐	**Allergic/Immunologic**: Asthma, hay fever, hives, rashes, seasonal

NAME _____DATE _____

FAMILY HISTORY: (CIRCLE ANY POSITIVES AND EXPLAIN)

Family history not known_____

EYE: Amblyopia, blindness, cataracts, crossed eyes, diabetic retinopathy, macular degeneration, glaucoma, retinal detachment. Explain: _____

OTHER: cancer, diabetes, heart disease, high blood pressure, stroke, other
EXPLAIN_____

SOCIAL HISTORY:

Smoking: no__ yes__ pks/day___ how long _____ quit_____
Alcohol: no__ yes__ how much?_____
Street Drugs/Illegal Substances: no___ yes___
Driving: no__ yes___ daytime only____
Living arrangements: alone____ with spouse____ other_____
Marital Status: single____ married____ divorced____ widowed____
Occupation: _____

FOR OFFICE USE ONLY

RECAP – Past Eye History/Surgery (Date, Diagnosis, Therapy, Surgery, M.D.)

I confirm that all (3) pages of history as recorded herein was reviewed with the patient. Additions made as noted.
_____M.D.
_____Tech

MEDICATIONS LIST FOR _____ DOB: _____

Are you allergic to any medicines? ☐ Yes ☐ No

If YES, please list:_____

SYSTEMIC MEDICATION	DOSAGE	OFFICE STAFF USE ONLY

HERBALS, SUPPLEMENTS, OVER –THE-COUNTER MEDICATIONS

TECH/DATE (review of meds&health)
