PETER L. LOU, M.D.
Vitreoretinal Specialist

PETER Y. CHANG, M.D.
Ocular Inflammatory Disease and Vitreoretinal Specialist

10 Hawthorne Place, Suite 106
Boston, MA 02114

Massachusetts Eye Research and Surgery Institution
Est. 2005

Appointments: 617-523-0955 • Fax: 617-523-5376
Web: www.mersi.com • Email: pchang@mersi.com • plou@mersi.com

Dear New Patient,

We are pleased to welcome you to the Massachusetts Eye Research and Surgery Institution (MERSI). For us to provide you with the best patient experience, we need you to review and complete this new patient packet. This packet includes important information regarding your billing policy for you to read and sign below.

Please be sure to fill out the following sections:

- Primary care physician (PCP) – HMO's require a referral
- Referring doctor
- Email address
- Emergency contact information

The doctors request all new patients complete the new patient packet and completed forms to the day of your appointment. We recommend you arrive 15 minutes before your scheduled time to allow us to enter the information. You may also fax the information to MERSI before your appointment at (617) 523-5376.

New patient appointments at MERSI are very thorough, and your physician may order additional testing during your visit. It is not uncommon for a complicated new patient appointment to last four hours or longer, and we ask you to plan accordingly.

If you have any questions regarding your appointment at the Boston location, please call (617) 523-0955.

Sincerely,

MERSI Boston Team

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THIS PAGE IS FOR NON-INSURANCE, INACTIVE INSURANCE, AND NON-REFERRAL HMO'S
(skip this page if you have active health insurance)

Please initial after you have reviewed each line:

If you do not have health insurance or your health insurance is inactive, the fee for the consultation with Dr. Lou or Dr. Chang is $650. We also require an additional $250 for a deposit for possible diagnostic testing. **Initial:** _____

If no testing is needed, the $250 deposit will be reimbursed at the end of the visit.
Initial: _____

If testing is needed, you will be brought to the Front Desk and informed of the costs of each test. The costs of some tests *may exceed* the $250 deposit you paid at the beginning of your visit or *less than* the $250 deposit you paid. **Initial:** _____

Please initial after you review a few of your options:

1. You have the option of being reimbursed the $250 deposit and re-scheduling the tests.
   Initial: _____

2. If the testing costs exceeds the $250 deposit, you will pay any additional costs that exceed the $250 deposit and have the testing done here on the same day as your appointment.
   Initial: _____

3. If the testing costs are less than the $250 deposit, you will be reimbursed any remaining difference from the $250 deposit and have the testing done the same day.
   Initial: _____

I have read the payment policy and agree to pay in-full all charges for today's visit.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Name of legal guardian (if applicable): _____ **Date:** _____

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Medical Insurance: Explanation and Information

Patient Name: _____ **Date of Birth: _____**

Our office will bill your insurance company for all of the services provided to you (office visits, surgeries, procedures, etc.). Reimbursement from your insurance to our office is based on our contractual agreement and our participation status.

Your benefit plan will determine your responsibilities for several types of payments. The terms under which insurance policies establish these limitations on reimbursement vary widely among policies and depend on your individual contract and benefit plan.

As the patient, it is your responsibility to know your insurance policy and benefits. We strongly encourage you to contact your insurance company to verify your plan benefits (copayments, deductible, and/or coinsurance). Co-payments, deductibles, coinsurance and non-covered services are the member's responsibility, and will be collected up front.

Copayment: A fixed amount that your insurance company may require you to pay to the physician at the time of service. A copayment may be due for each visit, depending on the type of service you require. I agree to pay my copayment at each visit as determined by my insurance plan. **Initial:** _____

Deductible: The amount you are responsible to pay for Medical services rendered, before coverage begins, each plan year. Some insurance carriers have individual deductibles, and/or family deductibles, which are required before they will make payment for eligible benefits. I agree to pay my deductible to MERSI as determined by my insurance policy. **Initial:** _____

Coinsurance: After your deductible has been satisfied, your insurance company will pay a percentage of the eligible amount of charges for services. You could be responsible for the remaining percentage of expenses beyond the deductible (up to a maximum). The percentage is determined by your benefit plan structure with your insurance company. I agree to pay my coinsurance at each office visit as determined by my insurance policy. **Initial:** _____

It is our office policy to collect your copayment at the time of service, when you check in for your appointment. We will also collect a full or partial payment for your office vi it, procedure(s) and/or surgery, if your deductible and/or coinsurance has not been met (unless other payment arrangements have been approved by our office).

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I have read and agree to the terms above and understand I will be responsible for all payments associated with my insurance policy.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Name of legal guardian (if applicable): _____ Date: _____

Signature of legal guardian (if applicable): _____ Date: _____

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Patient Name: _____ **Date of Birth:** _____

Phone Number: _____ **Mobile Number:** _____

Address: _____

Email address: _____

Name of Primary Doctor (*required*): _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Fax Number:** _____

Name of Referring Ophthalmologist: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Fax Number:** _____

Name of Any Other Specialist or Doctor: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Fax Number:** _____

Emergency Contact Information

Emergency Contact Name: _____ **Date of Birth:** _____

Relationship: _____ **Phone Number:** _____

Pharmacy Information for Medication Refills

Pharmacy Name: _____

Address: _____

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City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

How did you hear about MERSI? *(please check off which best applies)*

PCP____ OPHTHALMOLOGIST____ OPTOMETRIST____ SPECIALIST____ MGH____

MOUNT AUBURN____ INSURANCE COMPANY____ FACEBOOK____ INTERNET____

OTHER (please specify) _____

PATIENT____ PATIENT'S NAME_____

If you were referred by a patient, may we use your name in thanking him/her? YES____ NO____

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MERSI ADDITIONAL DEMOGRAPHICS

Patient Name: _____ **Date of Birth: _____**

Email address: _____

Please select the most appropriate option for each of these:

Race

_____American Indian or Alaska Native Asian

_____Black or African American

_____Native Hawaiian or other Pacific Islander

_____Unknown/Not Reported White

_____White or Caucasian

Ethnicity

_____Hispanic or Latino

_____Not Hispanic or Latino

_____Unknown/Not Reported

Language

_____Arabic

_____Bulgarian Cambodian Central Khmer Chinese

_____English

_____French Haitian Creole Hebrew

_____Hindi Italian

_____Japanese Korean Polish

_____Portuguese Russian Somali

_____Spanish; Castilian Swahili

_____Thai Urdu

_____Vietnamese

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for MERSI.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby consent to MERSI disclosure of my medical information so that MERSI may treat me, seek payment from third parties for such treatment, and generally carry on MERSI's health care operations (e.g., planning or other administrative activities.) I also consent to MERSI's disclosure of my medical information to insurers and providers outside of MERSI, when necessary, so these providers may treat me, seek payment for that treatment, and generally carry on their own health care operations. I also consent MERSI's disclosure of my medical information on my home answering machine/voice mail at the number below. I also consent to MERSI's disclosure of my medical information to observers, trainees (medical school students and medical school graduates) and fellows (licensed physicians) volunteering and working at MERSI, consistent with the educational mission of MERSI. I also consent to MERSI's disclosure of my medical information for charitable fundraising purposes, including, but not limited to disclosures to Ocular Immunology and Uveitis Foundation, Inc. I also consent to MERSI's use and disclosure of my medical information for the purpose of medical research projects.

Signature: _____ Date: _____

Phone Number: _____

If the patient is a minor child or is otherwise incapacitated (physically or mentally), complete the following:

Signature of Personal Representative _____

Description of Authority_____ Date _____

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OCULAR INFLAMMATORY DISEASE REVIEW OF SYSTEMS QUESTIONNAIRE

This is a **confidential** survey. Please respond to all questions by circling the proper answer. Please bring this with you to your appointment.

Patient Name: _____ **Date of Birth: _____**

Reason for your visit: _____

FAMILY HISTORY: These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in your family had any of the following? (please add anything else we should know in the blank box)

CANCER	**YES**	**NO**	
DIABETES	**YES**	**NO**	
ALLERGIES	**YES**	**NO**	
ARTHRITIS OR RHEUMATISM	**YES**	**NO**	
SYPHILIS	**YES**	**NO**	
TUBERCULOSIS	**YES**	**NO**	
SICKLE CELL DISEASE OR TRAIT	**YES**	**NO**	
LYME DISEASE	**YES**	**NO**	
GOUT	**YES**	**NO**	

Has anyone in your family had any of the following medical problems below?

EYES	**YES**	**NO**	
SKIN	**YES**	**NO**	
KIDNEYS	**YES**	**NO**	
LUNGS	**YES**	**NO**	
STOMACH OR BOWEL	**YES**	**NO**	
NERVOUS SYSTEM OR BRAIN	**YES**	**NO**	

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YOUR SOCIAL HISTORY

Current Job: _____ **Name of Employer _____**

Have you ever lived outside of the USA?	**YES**	**NO**
If yes, where?		
Have you ever owned a dog?		
Have you ever owned a cat?		
Have you ever eaten raw meat or uncooked sausage?		
Have you ever had unpasteurized milk or cheese?		
Have you ever been exposed to sick animals?		
Do you ever drink untreated stream, well or lake water?		
Do you currently use tobacco products?		
Have you ever used recreational drugs injected in the vein?		
Have you ever had bisexual or homosexual relationships?		
Do you currently take or have taken birth control pills in the last 5 years?		

MEDICATIONS

Are you allergic to any medications?	**YES**	**NO**

IF yes, please list all allergies, including any medications you take for this:

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Please list all eye drops:

DRUG	DOSAGE	FREQUENCY/EYE

Please list all other medications:

DRUG	DOSAGE	FREQUENCY

Please list all eye surgeries with dates:

SURGERY	DATE

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Please list all other medical history:

MEDICAL HEALTH PROBLEMS	DATE

Please list all non-eye surgeries:

SURGERY	DATE

Have you ever been told that you have the following conditions?

ANEMIA (LOW BLOOD COUNTS)	YES	NO
CANCER	YES	NO
DIABETES	YES	NO
HEPATITIS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
PLEURISY	YES	NO
PNEUMONIA	YES	NO
ULCERS		

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HERPES (COLD SORES)	**YES**	**NO**
CHICKEN POX	**YES**	**NO**
SHINGLES (ZOSTER)	**YES**	**NO**
GERMAN MEASLES (RUBELLA)	**YES**	**NO**
MEASLES (RUBEOLA)	**YES**	**NO**
MUMPS	**YES**	**NO**
CHLAMYDIA OR TRACHOMA	**YES**	**NO**
SYPHILIS	**YES**	**NO**
GONORRHEA	**YES**	**NO**
ANY OTHER SEXUALLY TRANSMITTED DISEASE	**YES**	**NO**
TUBERCULOSIS (TB)	**YES**	**NO**
LEPROSY	**YES**	**NO**
LEPTOSPIROSIS	**YES**	**NO**
LYME DISEASE	**YES**	**NO**
HISTOPLASMOSIS	**YES**	**NO**
CANDIDA OR MONILIASIS	**YES**	**NO**
COCCIDIOMYCOSIS	**YES**	**NO**
SPOROTRICHOSIS	**YES**	**NO**
TOXOPLASMOSIS	**YES**	**NO**
TOXOCARIASIS	**YES**	**NO**
CYSTICERCOSIS	**YES**	**NO**
TRICHINOSIS	**YES**	**NO**
WHIPPLE'S DISEASE	**YES**	**NO**
AIDS	**YES**	**NO**
HAY FEVER	**YES**	**NO**
ALLERGIES	**YES**	**NO**
VASCULITIS	**YES**	**NO**

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ARTHRITIS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
LUPUS (SYSTEMIC LUPUSERYTHEMATOSUS)	YES	NO
SCLERODERMA	YES	NO

Have you ever had any of the following illnesses?

REITER'S SYNDROME	YES	NO
COLITIS	YES	NO
CROHN'S DISEASE	YES	NO
ULCERATIVE COLITIS	YES	NO
BEHCET'S DISEASE	YES	NO
SARCOIDOSIS	YES	NO
ANKYLOSING SPONDYLITIS	YES	NO
ERYTHEMA NODOSA	YES	NO
TEMPORAL ARTERITIS	YES	NO
MULTIPLE SCLEROSIS	YES	NO
SERPIGINOUS CHOROIDOPATHY	YES	NO
FUCHS' HETEROCHOROMIC IDIDOCYCLITIS	YES	NO
VOGT-KOYANAGI-HARADA SYNDROME	YES	NO

Have you had any of the following symptoms in the past year?

GENERAL HEALTH:

CHILLS	YES	NO
FEVERS (PERSISTENT OR RECURRENT)	YES	NO
NIGHT SWEATS	YES	NO
FATIGUE (TIRE EASILY)	YES	NO
POOR APPETITE	YES	NO
UNEXPLAINED WEIGHT LOSS	YES	NO
DO YOU FEEL SICK?	YES	NO

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Have you had any of the following symptoms in the past year?

HEAD:

FREQUENT OR SEVERE HEADACHES	YES	NO
FAINTING	YES	NO
NUMBNESS OR TINGLING IN YOUR BODY	YES	NO
PARALYSIS IN PARTS OF YOUR BODY	YES	NO
SEIZURES OR CONVULSIONS	YES	NO

EAR:

HARD OF HEARING OR DEAFNESS	YES	NO
RINGING OR NOISES IN YOUR EARS	YES	NO
FREQUENT OR SEVERE EAR INFECTIONS	YES	NO
PAINFUL OR SWOLLEN EAR LOBES	YES	NO

NOSE AND THROAT:

SORES IN YOUR NOSE OR MOUTH	YES	NO
SEVERE OR RECURRENT NOSEBLEEDS	YES	NO
FREQUENT SNEEZING	YES	NO
SINUS TROUBLE	YES	NO
PERSISTENT HOARSENESS	YES	NO
TOOTH OR GUM INFECTIONS	YES	NO

SKIN:

RASHES	YES	NO
SKIN SORES	YES	NO
SUNBURN EASILY (PHOTOSENSITIVITY)	YES	NO
WHITE PATCHES OF SKIN OR HAIR	YES	NO
LOSS OF HAIR	YES	NO
TICK OR INSECT BITES	YES	NO
PAINFULLY COLD FINGERS	YES	NO
SEVERE ITCHING	YES	NO

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RESPIRTORY:

SEVERE OR FREQUENT COLDS	YES	NO
CONSTANT COUGHING	YES	NO
COUGHING UP BLOOD	YES	NO
RECENT FLU OR VIRAL INFECTION	YES	NO
WHEEZING OR ASTHMA ATTACKS	YES	NO
DIFFICULTY BREATHING	YES	NO

CARDIOVASCULAR:

CHEST PAIN	YES	NO
SHORTNESS OF BREATH	YES	NO
SWELLING OF YOUR LEGS	YES	NO

BLOOD:

FREQUENT OR EASY BRUISING	YES	NO
FREQUENT OR EASY BLEEDING	YES	NO
HAVE YOU RECEIVED ANY BLOOD TRANSFUSIONS	YES	NO

GASTROINTESTINAL:

TROUBLE SWALLOWING	YES	NO
DIARRHEA	YES	NO
BLOODY STOOLS	YES	NO
STOMACH ULCERS	YES	NO
JAUNDICE OR YELLOW SKIN	YES	NO

BONES AND JOINTS:

STIFF JOINTS	YES	NO
PAINFUL OR SWOLLEN JOINTS	YES	NO
STIFF LOWER BACK	YES	NO
BACK PAIN WHILE SLEEPING OR AWAKENING	YES	NO
MUSCLE ACHES	YES	NO

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Have you had any of the following symptoms in the past year?

GERINTOURINARY:

KIDNEY PROBLEMS	YES	NO
BLADDER TROUBLE	YES	NO
BLOOD IN YOUR URINE	YES	NO
URINARY DISCHARGE	YES	NO
GENITAL SORES OR ULCERS	YES	NO
PROSTATITIS	YES	NO
TESTICULAR PAIN	YES	NO

OTHER:

ARE YOU PREGNANT?	YES	NO
DO YOU PLAN TO BE PREGNANT IN THE FUTURE?	YES	NO

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