GLAUCOMA SPECIALISTS

Welcome! I would like to take this time to introduce myself and the practice.

About the Practice

Ophthalmologists are medical doctors who specialize in eye care. In addition to being an ophthalmologist, I have received advanced training in the diagnosis, medical management, and surgical care of eye disorders due to glaucoma.

If you have been referred for consultation, I will keep your doctor informed about your condition and the treatment that you receive. I will advise you when to return to your referring doctor's care.

The Initial Visit

The initial consultation may be quite involved. We will ask you about your general health, your eyes, and the medications that you take. **Please bring all of your medications (pills and eye drops) with you. It is also necessary for you to bring your current glasses**. It is important for you to take all of your medications, as you normally would, on the day of your visit.

I will examine your eyes thoroughly. Depending upon the nature of your problem, several different tests may be performed. **Please allow about three hours for this initial visit**. It is likely that your eyes will be dilated during the course of this examination. It is suggested that you bring someone along to drive you home or a pair of dark sunglasses.

I will try to see you as promptly as possible. Sometimes, because of emergencies, there may be a delay. If you are running on a tight schedule, please feel free to call the office to see if I am running late.

Information Packets

My office staff has enclosed a detailed information packet for you. **Please take the time to read, fill out, and sign the attached forms.** You will need to bring these with you, along with your insurance cards and ID / driver's license on the day of your visit.

Thank you

Alan L. Robin, M.D.

ALAN L. ROBIN, MD
6115 FALLS ROAD, STE 333
BALTIMORE, MARYLAND 21209

PHONE: 410-377-2422
FAX: 410-377-7960
EMAIL:AROBIN@GLAUCOMAEXPERT.COM

Alan L. Robin, MD, is both a key global opinion leader and is a leader in the clinical management and scientific study of glaucoma. His emphasis is on treating patients as he would like to be treated himself, maximizing avenues of doctor patient communication.

Dr. Robin is a member of two prestigious and highly selective organizations: both the American Ophthalmological Society (one of the oldest medical societies in the nation which requires a thesis) and the Glaucoma Research Society (a highly selective society limited to 80 members of the best glaucoma researchers in the world). He was a founding member of the American Glaucoma Society and has been a member for over thirty years. He is a silver fellow of the Association for Research in Vision and Ophthalmology.

Dr. Robin has been a best doctor in Baltimore on multiple occasions. He has frequently been a best doctor in America. He has been an invited lecturer in all continents. He has delivered the Venkataswamy Oratory lecture, the Kapetansky Lecture, the Janice Kushner Memorial Lecture for the International Glaucoma Association, as well as the Shaffer lecture at the American Academy of Ophthalmology.

Dr. Robin is an innovator. He has developed and perfected novel laser therapies as well as new medications, helping in the treatment of glaucoma. He has published over 230 peer-reviewed papers in his career. He is a patient advocate.

Dr. Robin holds joint Associate Professorships in Ophthalmology and in International Health at the Johns Hopkins University and is an adjunct Professor at the University of Michigan. He has been the co-director of the Glaucoma Service at the Greater Baltimore Medical Center. Additionally, he is a Professor of Ophthalmology at the VA system and is actively involved with teaching optometry as well as ophthalmology. He has in fact trained as fellows and residents dozens of current departmental chairs.

His current research interests have included the use of newer delivery systems for medications to treat open-angle glaucoma, innovative collaborative screening for glaucoma and diabetic retinopathy, and improving adherence to glaucoma therapies. He is also deeply involved in both the global eradication of needless blindness and establishing strategies for better eye care delivery. He has extensive experience in managing big data both from insurance and Medicare data bases. He has worked actively and designed randomized clinical trials involving both medical and surgical interventions.

Dr. Robin has worked as a consultant to the FDA and as a consultant to industry to develop protocols and problem solve in collaboration with the FDA. He has helped get medications approved with the VA system and has worked closely both with the American Academy of Ophthalmology and with managed care in formulary matters. He is a currently a member of the ANSI committee to develop new FDA algorithms for approving early stage glaucoma surgical devices.

He has won many honors and awards during his career, among them the Honor, Senior Honor, and Secretariat Awards of the American Academy of Ophthalmology. Additionally he has also received the Outstanding Humanitarian Service award of the American Academy of Ophthalmology, the Dr. Venkataswamy Oration Award, the American Glaucoma Society Humanitarian Award, and the silver achievement award of the Associate of Ophthalmology and Visual Sciences. As he is noted for his intellect and scientific ability, he is also noted for his selfless humanitarian work both in the US and globally. He was the first international scholar in residence at the University of Michigan.

Alan L. Robin, MD, PA
Lake Falls Professional Building • 6115 Falls Road, Suite 333 • Baltimore, MD 21209-2226
Telephone 410-377-2422 • Fax 410-377-7960

Alan L. Robin, MD
Professor of Ophthalmology,
University of Maryland
Associate Professor of Ophthalmology
And International Health,
Johns Hopkins University

Melissa Smith, O.D.
Residency Trained in Ocular Diseases
Specializing in Glaucoma and
Comprehensive Eye Care

Notice of Privacy Practices

To Our Patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information In Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. Public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are in inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Rights Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you

may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Alan L. Robin, M.D., P.A.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to our Office Administrator; please note that you must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Alan L. Robin, M.D., P.A.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Office Administrator. All complaints must be submitted in writing, and you will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Office Administrator at 410-377-2422.

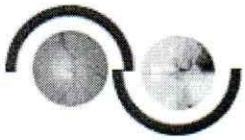
I hereby acknowledge that I have been presented with a copy of Alan L. Robin, M.D., P.A. Notice of Privacy Practice:

Patient Signature: _____ Date: _____

Other Authorized or Required to Consent Signature (Relationship):

_____

Printed Name of Patient: _____



Alan L. Robin, MD, PA
Lake Falls Professional Building • 6115 Falls Road, Suite 333 • Baltimore, MD 21209-2226
Telephone 410-377-2422 • Fax 410-377-7960

Alan L. Robin, MD
Professor of Ophthalmology,
University of Maryland
And International Health,
Johns Hopkins University

Melissa S. Smith, OD
Residency Trained in Ocular Diseases
Specializing in Glaucoma and
Comprehensive Eye Care

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY, STATE AND ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

SEX: _____ RACE: _____ MARITAL STATUS: M D W S SEP.

DATE OF BIRTH: _____ PRESENT AGE: _____

SOCIAL SECURITY #: _____

EMPLOYER: _____

REFERRED BY: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

CITY, STATE, AND ZIP: _____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

SPOUSE NAME AND PHONE #: _____

SPOUSE EMPLOYER: _____

PERSON NOT IN HOUSEHOLD TO CONTACT: _____

PHONE #: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

ADDRESS: _____

_____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER SOCIAL SECURITY #: _____

RELATIONSHIP: _____

(OVER PLEASE)

INSURANCE INFORMATION CONTINUED

SECONDARY INSURANCE: _____

ADDRESS: _____

_____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER SOCIAL SECURITY #: _____

RELATIONSHIP: _____

TERTIARY INSURANCE: _____

ADDRESS: _____

_____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER SOCIAL SECURITY #: _____

RELATIONSHIP: _____

LIFETIME ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE TO ME OR ON MY BEHALF TO ALAN L. ROBIN, MD, PA FOR ANY SERVICES FURNISHED ME BY THAT FACILITY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES

I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE BECAUSE OF CO-PAY, DEDUCTIBLE, REFERRAL/AUTHORIZATION NOT OBTAINED PRIOR TO VISIT, OR INCORRECT INSURANCE INFORMATION."

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

(OTHER AUTHORIZED OR REQUIRED TO CONSENT)

_____

ALAN L. ROBIN MD,PA
MEDICAL HISTORY FORM

NAME_____ Today's Date_____

DATE OF BIRTH_____

DOCTOR REFERRING YOU_____

PRIMARY CARE PHYSICIAN_____

PRIMARY CARE PHONE # _____ FAX #_____

PAST MEDICAL HISTORY

List ALL prescription medications you take/the dosage and times per day:_____

_____

_____

_____

List ALL Herbal Supplements you now take:_____

_____

List ALL Major Illnesses and Injuries:_____

_____

List ALL Surgeries you have had:_____

_____

Have you ever had MRSA, VRE or any serious drug resistant Infection? ( ) YES ( ) NO

Are you ALLERGIC TO ANY MEDICATIONS? YES NO List the medication and reaction:_____

_____

Are you ALLERGIC TO Shellfish? YES NO
Are you ALLERGIC TO IVP Dye? YES NO
Are you ALLERGIC TO IODINE? YES NO

Other Allergies? List the allergy and reaction_____

Are you Sensitive / Allergic to Rubber or Latex Products? ( ) YES ( ) NO Reaction:_____

SOCIAL HISTORY

Current or Past Occupation_____

Do you drive? ( )YES ( ) NO Do you smoke? ( ) YES, # packs/day ( ) NO

Do you drink alcohol? ( ) YES, # drinks/wk_____ ( ) NO

Have you ever had a blood transfusion? YES NO If yes, please give date_____
Have you ever been in intimate contact with a person who had a sexually transmitted disease? YES NO
Have you ever used street drugs? YES NO

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP
Blindness	[ ]	[ ]	_____
Cataracts	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____

NAME_____ Sex: M F Birthdate_____

REVIEW OF SYSTEMS

Do you have any problems in the following areas? Please check YES or NO. If "YES", provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms			
Do you have a Cold/Fever?	[ ]	[ ]	_____
Weight loss in the past 4 mths. without dieting	[ ]	[ ]	_____
Eyes			
Loss of Vision	[ ]	[ ]	_____
Loss of Side Vision	[ ]	[ ]	_____
Double Vision	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Burning	[ ]	[ ]	_____
Foreign Body Sensation	[ ]	[ ]	_____
Excess tearing / watering	[ ]	[ ]	_____
Glare / Light Sensitivity	[ ]	[ ]	_____
Eye pain / soreness	[ ]	[ ]	_____
Chronic infection of eye or eyelid	[ ]	[ ]	_____
Ears, Nose, Mouth, Throat			
Sinus Congestion	[ ]	[ ]	_____
Dry throat / mouth	[ ]	[ ]	_____
Chipped or loose teeth, dentures, caps, bridgework, braces?	[ ]	[ ]	_____
Respiratory (Lungs / Breathing)			
Asthma ,Pneumonia or Tuberculosis	[ ]	[ ]	_____
Wheezing	[ ]	[ ]	_____
COPD	[ ]	[ ]	_____
Abnormal chest x-ray	[ ]	[ ]	_____
Do you have a cough?	[ ]	[ ]	_____
Do you bring anything up when you cough?	[ ]	[ ]	_____
Difficulties with breathing	[ ]	[ ]	_____
Shortness of breath	[ ]	[ ]	_____
Do you use a CPAP?	[ ]	[ ]	_____
Do you wake up short of breath during the night?	[ ]	[ ]	_____
Can you walk up two flights of stairs without getting short of breath?	[ ]	[ ]	_____
Do you have sleep apnea?	[ ]	[ ]	_____
Have you been told you snore loudly or periods when you stop breathing in your sleep?	[ ]	[ ]	_____
Cardiovascular (heart / blood vessels)			
Angina / chest pain	[ ]	[ ]	_____
Heart murmur	[ ]	[ ]	_____
Heart attack	[ ]	[ ]	_____
High blood pressure	[ ]	[ ]	_____
High cholesterol	[ ]	[ ]	_____
Pacemaker/ICD	[ ]	[ ]	_____
Congestive Heart Failure	[ ]	[ ]	_____
Mitral Valve Prolapse	[ ]	[ ]	_____
Irregular heart beat	[ ]	[ ]	_____
Do you take any blood thinners?	[ ]	[ ]	_____

MEDICAL HISTORY FORM (continued)

NAME_____ Sex: M F Birthdate_____

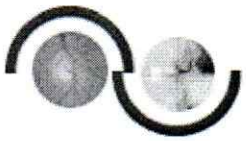
	YES	NO	Explanation of Problem
Gastrointestinal (stomach / intestines / liver)			
Heartburn or Reflux/GERD	[ ]	[ ]	_____
Peptic Ulcer Disease	[ ]	[ ]	_____
Hiatal Hernia	[ ]	[ ]	_____
Colitis	[ ]	[ ]	_____
Irritable Bowel Syndrome	[ ]	[ ]	_____
Diverticulitis	[ ]	[ ]	_____
Crohn's Disease	[ ]	[ ]	_____
Colon Cancer	[ ]	[ ]	_____
Jaundice	[ ]	[ ]	_____
Hepatitis	[ ]	[ ]	_____
Genitourinary (Genitals / kidney / bladder)			
If female, date of last menstrual period			_____
Could you be pregnant?	[ ]	[ ]	_____
Kidney problems	[ ]	[ ]	_____
Renal Disease	[ ]	[ ]	_____
Bladder problems	[ ]	[ ]	_____
Musculoskeletal			
Any Physical disabilities ?	[ ]	[ ]	_____
Numbness or weakness in an arm or leg	[ ]	[ ]	_____
Back problems	[ ]	[ ]	_____
Can you lie flat on your back in bed?	[ ]	[ ]	_____
Integumentary			
Skin problems	[ ]	[ ]	_____
Do you bruise easily?	[ ]	[ ]	_____
Do you have any open/draining/red wounds?	[ ]	[ ]	_____
Neurological			
Stroke	[ ]	[ ]	_____
Severe Headaches or Migraines	[ ]	[ ]	_____
Any history of head injury?	[ ]	[ ]	_____
Any episodes of Epilepsy, Seizures, Falling out?	[ ]	[ ]	_____
Endocrine (Diabetes / Thyroid)			
Do you have diabetes?	[ ]	[ ]	_____
Thyroid problems	[ ]	[ ]	_____
Hematologic – Lymphatic			
Any bleeding tendencies?	[ ]	[ ]	_____
Any history of blood clots?	[ ]	[ ]	_____
Have you ever been anemic?	[ ]	[ ]	_____
Allergy / Immunology			
Seasonal allergies	[ ]	[ ]	_____
Hay fever symptoms	[ ]	[ ]	_____
Psychiatric			
Have you ever been under the care of a Psychiatrist?	[ ]	[ ]	_____
Anxiety / Depression	[ ]	[ ]	_____
Do you feel safe in your home?	[ ]	[ ]	_____

PATIENT SIGNATURE_____ DATE_____

PATIENT NAME (PRINTED)_____

PHYSICIAN SIGNATURE_____ DATE_____

I attest that I have personally reviewed the above health survey and noted further information where appropriate.



Alan L. Robin, MD, PA
Lake Falls Professional Building • 6115 Falls Road, Suite 333 • Baltimore, MD 21209-2226
Telephone 410-377-2422 • Fax 410-377-7960

Alan L. Robin, MD
Professor of Ophthalmology,
University of Maryland
Associate Professor of Ophthalmology
And International Health,
Johns Hopkins University

Melissa S. Smith, OD
Residency Trained in Ocular Diseases
Specializing in Glaucoma and
Comprehensive Eye Care

REFRACTION POLICY

Refractions are not always performed on each visit. However you should be aware that Medicare, and most other insurance companies, do not cover refractions and will not pay for this service. Therefore payment for this procedure is expected at the time of service.

A refraction is a valuable diagnostic test and determined necessary even when an individual has 20/20 vision. This service is performed to assess the status of your visual system to determine if a medical problem such as cataract or macular degeneration might be the cause of diminished vision.

A refraction is performed to determine your best-corrected vision to distinguish medical eye problems from a simple need for new glasses. A glasses prescription is not necessarily given each time a refraction is perfor med.

Our fee for a refraction is $55.00

A deluxe refraction may be performed when a patient requires specialized measurements, has multiple pairs of glasses, and/or requires more time to evaluate the prescription.

Our fee for a deluxe refraction is $75.00.

Please do not hesitate to ask questions if you do not understand this policy.

Patient's Signature: _____ Date: _____

Dear Patient: **WE HAVE GREAT NEWS!**

We now have the ability to order your prescriptions electronically when we prescribe medications for you. You should make **all of your *refill* requests directly to your pharmacy.**

Please give us the name and address of your **preferred Pharmacy** so that we may have this information on file.

Thank you.

Patient Name: _____

Date of Birth: _____

Name of Pharmacy: _____

Address: _____

_____

Zipcode: _____

Telephone # of pharmacy: _____

☐ entered into Allscripts Date entered: _____