

Mon Tues Wed Thurs Fri

Appt Date: \_\_\_/\_\_\_/\_\_\_

Time: \_\_\_\_\_

Clinic: Sartell Alexandria Baxter

CENTRAL MINNESOTA **RETINA** SPECIALISTS

VITREORETINAL and MACULAR  
DISEASES and SURGERY

### Welcome to our Clinic,

We appreciate you choosing Central Minnesota Retina Specialists for your eye care. We look forward to educating you about your retinal diagnosis and taking care of you.

**Initial exams generally take 2-3 hours.** There are usually several tests and treatment options that can be done on the same day.

Please take some time to update us about your past medical history and sign the included consent forms. Use the postage paid return envelope or bring your completed forms with you on the day of your appointment.

If you have any questions about your insurance or the billing process, please call our billing department at 1-888-252-3020.

If you have any other questions, please call us at 1-866-667-8585 toll free or 320-230-8555.

We look forward to seeing you.

Sincerely,

Central Minnesota Retina Specialists

[www.centralmnretina.com](http://www.centralmnretina.com)

CENTRAL MINNESOTA **RETINA** SPECIALISTS

VITREORETINAL and MACULAR  
DISEASES and SURGERY

Dr. Reynolds was born in Minneapolis, Minnesota, and his parents and extended family are all from the Alexandria area. His family later moved to San Diego, California where he completed high school and college. In 1983 he graduated Summa Cum Laude with a Bachelor of Science degree in Biomedical Engineering from the University of California at San Diego.

He then went to Harvard University in Boston, Massachusetts, where he earned a Ph.D. in the Division of Medical Sciences, studying immunology. In 1992 he received his M.D. from Harvard Medical School and on graduation was awarded the medical school's Shipley Prize for "best published results of research." Dr. Reynolds was also awarded an Albert Schweitzer Fellowship to travel to Gabon, Africa, where he worked as an intern at the world-famous Albert Schweitzer Hospital in Labarene, Gabon.

Dr. Reynolds next completed an internal medicine internship at the University of California at San Francisco and then an ophthalmology residency at Los Angeles County Hospital/University of Southern California Medical Center and Doheny Eye Institute.

Dr. Reynolds, a Board Certified Ophthalmologist, has also completed subspecialty fellowship training in retina/vitreous diseases and surgery at Bascom Palmer Eye Institute, in Miami, Florida. Bascom Palmer has consistently been ranked as the number one or two ophthalmology training institute in the nation by U.S. News for many years. Following fellowship training, Dr. Reynolds served as the resident supervisor and chief of vitreoretinal surgery at Los Angeles County Hospital. Dr. Reynolds has extensive surgical experience with retinal detachment, severe diabetic retinopathy, retinopathy of prematurity, and ocular reconstruction after trauma.

Dr. Reynolds founded Central Minnesota Retina Specialists in November 2003, after five years working as a retina specialist in private practice. He enjoys spending time with his six children, playing piano, speaks Spanish and French.



Dale S. Reynolds, M.D., Ph.D.  
*Diplomate, American Board of Ophthalmology*

Toll-free: **1-866-667-8585**  
2330 Troop Drive, Suite 104, Sartell, MN 56377

CENTRAL MINNESOTA **RETINA** SPECIALISTS

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DISEASES and SURGERY

Dr. Gullapalli's story is one of overcoming long odds through hard work and excellence. He grew up and attended college in Bangalore, India. In competitive exams at the end of college he had to test in the top 1 percent to gain entrance into Bangalore Medical College. At the end of medical school he completed a year-long internship at Victoria and Bowring & Lady Curzon Hospitals, also in Bangalore.

Dr. Gullapalli spent the next ten years in the United States doing basic science research in retinal transplantation and experimental uveitis. His first position brought him in 1995 to work at the Doheny Eye Institute at the University of Southern California as a postdoctoral fellow. Later he moved to the University of Rochester in New York where he studied retinal transplantation. Dr. Gullapalli then completed his PhD in Neurosciences at the University of Medicine and Dentistry of New Jersey/Rutgers, working with Dr. Marco Zarbin in the Department of Ophthalmology on topics related to retinal aging and transplantation for macular degeneration. His work has appeared in numerous peer-reviewed research publications in major journals. He also co-authored chapters in major ophthalmology textbooks.

Dr. Gullapalli completed a second internship in surgery at Lenox Hill Hospital in New York City, and he completed his Ophthalmology Residency at the University of Medicine and Dentistry of New Jersey in 2009. Dr. Gullapalli is board certified in ophthalmology and has completed subspecialty fellowship training in vitreoretinal diseases and surgery at the University of Rochester in Rochester, New York.

Dr. Gullapalli worked for four years as a retina specialist in private practice before joining Dr. Reynolds at Central Minnesota Retina Specialists. After working for five years in MN, he returned to University of Rochester where he served as a Retina Fellowship Director and, in the final year, as Chief of Retina Service. He is excited to return to his favorite state to provide high quality local retina care to the Minnesotans again.

Dr. Gullapalli enjoys golf, guitar, saxophone, traveling, and is a car and aviation enthusiast.



Vamsi K. Gullapalli, M.D., Ph.D.  
*Diplomate, American Board of Ophthalmology*

Toll-free: **1-866-667-8585**  
2330 Troop Drive, Suite 104, Sartell, MN 56377

# Central Minnesota Retina Specialists

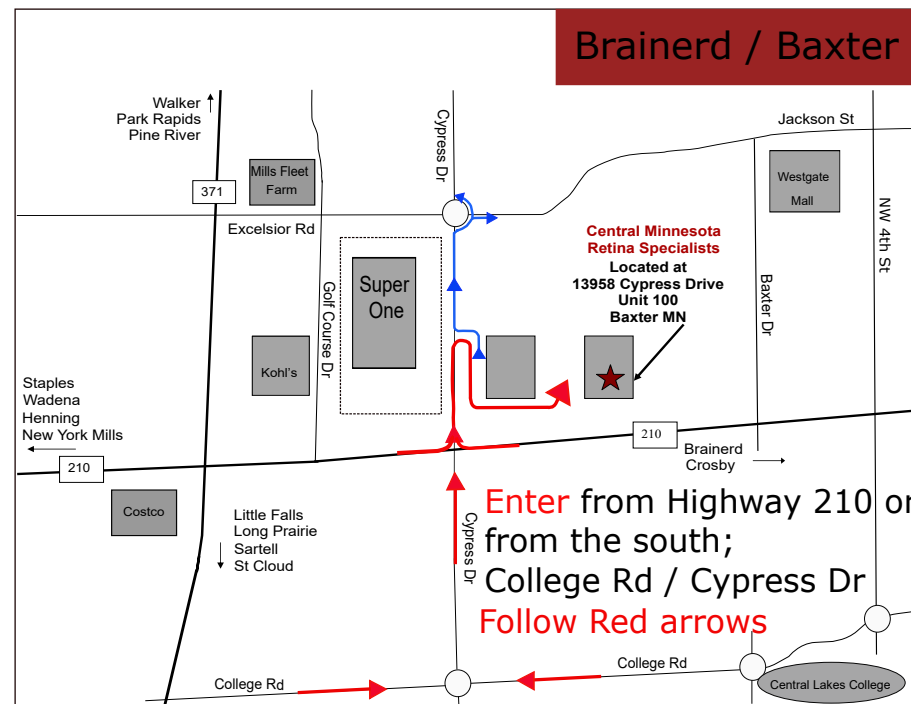
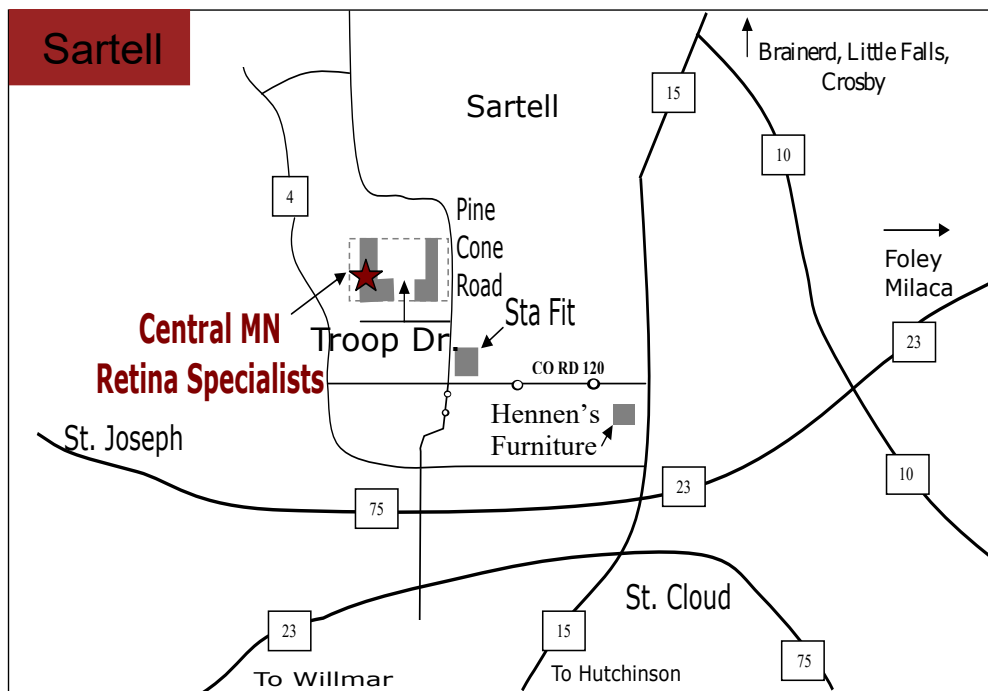
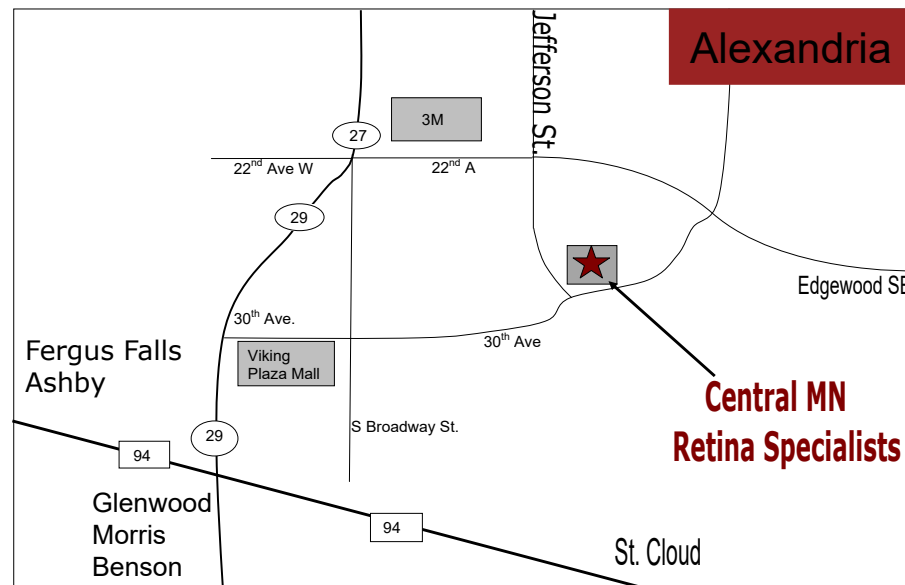
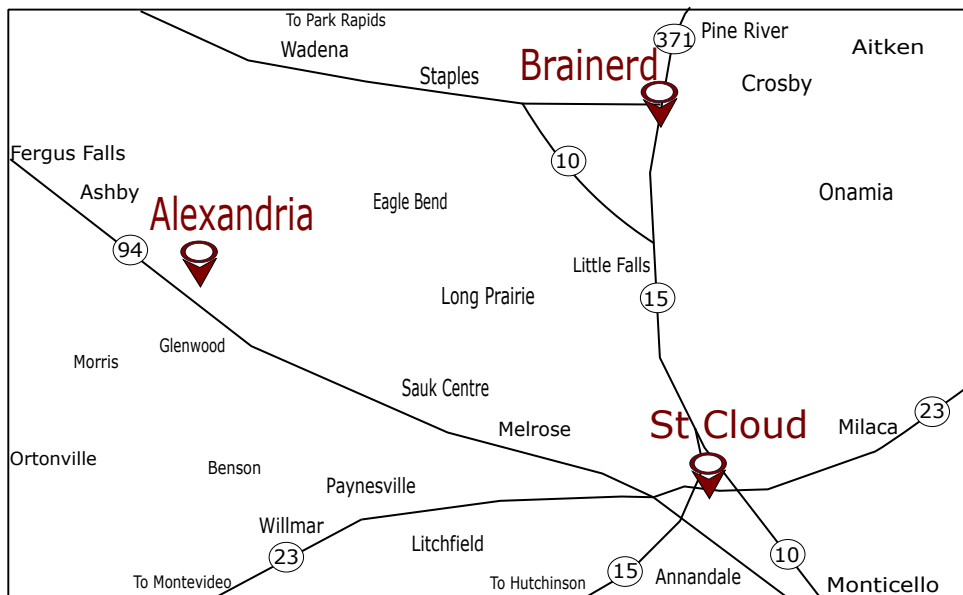
Serving Central Minnesota with Clinics In:

[www.centralmnretina.com](http://www.centralmnretina.com)

**St. Cloud:** 2330 Troop Dr. Unit 104, Sartell MN 56377

**Alexandria:** 2633 Jefferson St. Unit 802, Alexandria MN 56308

**Brainerd:** 13958 Cypress Dr., Baxter MN 56425



Exit is Right turn only on to Cypress Dr. Follow Blue arrows



## Patient Contact Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Alternative Phone: \_\_\_\_\_ Sex: Male or Female

E-mail Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employed\_\_ Retired\_\_ Disabled\_\_ Unemployed\_\_ Occupation: \_\_\_\_\_

Preferred Language: English\_\_ Other: \_\_\_\_\_ SS# \_\_\_\_\_

## Emergency Contact Information

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number (preferably different than patients): \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

Clinic Name: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_

Clinic Name: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other Doctor (if applicable):** \_\_\_\_\_ Specialty: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



## CURRENT EYE PROBLEM

### What is your main vision symptom?

Blurred vision

Floaters

Loss of vision

Flashes

Distortion of vision

Other:

### Which eye?

Right

Left

Both

### How did it start?

Sudden

Gradual

### How Severe is it?

Mild

Moderate

Severe

### How long has this been going on?

### Location of problem:

Central Vision

Entire field of view

unable to localize

### EYE MEDICATIONS: (please list below)

or check

None

Eye drop name

How many times per day

Which eye

Complete both sides >>>

## PERSONAL MEDICAL CONDITIONS

Please check off all that apply below.

If **NONE** apply please check the NONE check box in each section.

<b>Cardiovascular:</b> <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke	<b>Constitutional:</b> <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/large blood loss <input type="checkbox"/> Developmental disability <input type="checkbox"/> Alzheimer's	<b>Endocrine:</b> <input type="checkbox"/> None <input type="checkbox"/> Type I Diabetes – Last A1C ____ <input type="checkbox"/> Type II Diabetes – Last A1C ____ <input type="checkbox"/> Thyroid problem (high/low) <input type="checkbox"/> Hormonal dysfunction
<b>Gastrointestinal:</b> <input type="checkbox"/> None <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis	<b>Genitourinary:</b> <input type="checkbox"/> None <input type="checkbox"/> Kidney disease <input type="checkbox"/> Urinary tract infections	<b>Hematological:</b> <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia
<b>Ears/Nose/Throat:</b> <input type="checkbox"/> None <input type="checkbox"/> Hearing loss <input type="checkbox"/> Upper respiratory infection	<b>Immunologic:</b> <input type="checkbox"/> None <input type="checkbox"/> Aids/HIV <input type="checkbox"/> Lupus	<b>Integumentary:</b> <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis
<b>Musculoskeletal:</b> <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia	<b>Neurologic:</b> <input type="checkbox"/> None <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy	<b>Psychiatric:</b> <input type="checkbox"/> None <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
<b>Respiratory:</b> <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> COPD	<b>Any other medical conditions:</b> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>	

## SURGICAL HISTORY (please list ALL past surgeries & year done)

If no surgeries then check **None**

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## CURRENT MEDICATIONS

Please list **ALL** current medications **OR** bring a printed list of all current medications

If no medications are taken then check

**None**

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## ALLERGIES

Please list **ALL** medication allergies

If no allergies then check

**None**

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## FAMILY HISTORY

Please place a check mark in each box that is applicable

	Mother	Father	sibling	children	or check	<b>None</b>
Glaucoma						
Macular Degeneration						
Retinal Detachment						

## SOCIAL HISTORY

### Smoking/Tobacco:

Never smoker

Former smoker

Current everyday smoker

Vaping

Chew

Do you drive?

Yes

No

Have you fallen in the past 12 months?

Yes

No



## Authorization to Release Medical Information

I understand that at any time, I may obtain a copy of Central Minnesota Retina Specialists (CMRS) Notice of Privacy Practices.

I authorize CMRS, to release any medical information about me to all my other health care providers. (examples: the doctor who referred you, primary care doctor)

I authorize, CMRS, to release any Protected Health Information about me to the following persons: (Typical choices would be spouse, child(ren), friend)

\_\_\_\_\_

I authorize CMRS, to release any Protected Health Information about me to my insurance companies and claims clearinghouse as necessary to pay claims for services provided.

I authorize CMRS, to release any Protected Health Information about me to Clinical Registries.

I authorize CMRS, to leave a message, with a call back number or appointment reminder, on voicemail at any phone numbers I provide to CMRS.

Do you have a Medical Power of Attorney? YES or NO

If yes, name of Medical Power of Attorney: \_\_\_\_\_

Please provide a copy of supporting documents for your medical record.

I certify that this Authorization has been made voluntarily and the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time by completing Central Minnesota Retina Specialists' form, so long as the company has not yet relied upon and/or acted upon Authorization. I understand that information used or disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it. A copy or facsimile of the Authorization with my signature may be used with the same effectiveness as an original.

This authorization and assignment will remain in effect until revoked by me in writing.

Printed name: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent or Legal Guardian if Patient is a minor: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



# Insurance Verification

We are happy to bill your insurance carrier on your behalf for charges you incurred during your visits at Central Minnesota Retina Specialists. In order to do so we need accurate information about your insurance coverage.

## Patients with Medicare:

Have you purchased a Medicare Advantage or cost plan? Yes \_\_\_ No \_\_\_

This is an insurance plan that replaces your Medicare plan. This insurance would be the only insurance used to pay your doctor bills. These are typically offered by private insurers such as Blue Cross Blue Shield, Medica, Humana, etc. If you have a Medicare Advantage or cost plan please only present this insurance card to us and note only one insurance below.

Please call your insurance company to answer the following questions:

How much is your copay? \_\_\_\_\_

**We will collect your co-pay amount at your appointment.**

How much is your deductible (if applicable)? \_\_\_\_\_

**We will collect your deductible amount at your appointment. Please call Ashley in our billing office to get an estimate at 1-888-252-3020.**

What is your co-insurance % (if applicable)? \_\_\_\_\_

For example if you pay 20% of charges. **We will collect your co – insurance amount at your appointment. Please call Ashley in our billing office to get an estimate at 1-888-252-3020.**

Does your insurance require a referral or prior authorization? Yes \_\_\_ No \_\_\_ if yes, please call you primary care physician to obtain one prior to arriving at our office. The referral must be received by us before your appointment.

Do you have two or more insurances?

If yes, please call both of your insurance companies to confirm which insurance pays the bill first.

My only, first, or primary insurance is: \_\_\_\_\_

My secondary insurance is (if applicable) : \_\_\_\_\_

I acknowledge that I have presented my insurance coverage to be true and have not falsified or omitted any information.

Please bring your insurance cards to your visits.

Please update Central Minnesota Retinal Specialists with any changes to your insurance coverage

**Complete both sides>>>**

Patient \_\_\_\_\_ Date \_\_\_\_\_

## Billing Policies

**Financial Responsibility:** I understand and agree that I am financially responsible for payment of any service provided to me, my spouse or to my minor child(ren) not covered by insurance, including but not limited to, deductibles and co-insurance.

**Copayments:** I understand and agree that it is my responsibility to pay any co-pay listed on my insurance card at the time of service.

**Insurance:** We participate in a variety of insurance plans and will directly bill your insurance under these plans. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of your medical care within a reasonable time, regardless of status of a claim. Services not covered by your insurance are your responsibility. **I request and agree that payment of authorized insurance benefits be made to Central Minnesota Retina Specialists, for any services rendered.**

**Prior Authorization:** Some health maintenance organization (HMO) plans require you to obtain authorization for services from your primary care provider (internist, family practitioner, pediatrician, etc.) before you visit our office. *I understand it is my responsibility to obtain authorization from my primary care provider even when the visit is for an urgent problem.*

**We Participate with Medicare:** We are participating providers under Medicare. This means we accept the fees set by Medicare for medical services covered by the Medicare program, including surgery. Medicare patients will be responsible only for copayments, deductibles and non-covered services, such as refractions and routine eye exams.

I request that payment of authorized Medicare benefits be made on my behalf to Central Minnesota Retina Specialists (CMRS), for services furnished me by CMRS. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorized releasing the information to the insurer or agency shown. CMRS accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

**Electronic conversion of check payments:** I do hereby authorize Central Minnesota Retina Specialists to initiate a debit, in the amount written on my check, to my checking/savings account at the depository financial institution(Bank) identified by the routing number on my check and bank to debit same to such account. I acknowledge that I have received services/goods in consideration hereof and I further agree that this authorization shall be non-revocable. I agree to pay merchant a returned item fee in accordance with the merchant's return policy, which may be initiated to my account for the items returned unpaid.

**Credit card Payments:** I agree to pay the above amount according to the card issuer agreement. We accept Visa, MasterCard, American Express and Discover.

**Bill Collection:** If billing is necessary, a statement will be mailed to you and is due upon receipt. Charges and payments for services received during the last few days before your billing date may appear on the following month's statements. **I understand failure to make payment on my bill will result in my account being turned over to a third party collection agency. I understand the fee charged by the collection agency will be added to my bill.**

**Termination of Care:** I acknowledge that an overdue balance of 30 days or more that is not addressed to the satisfaction of Central Minnesota Retina Specialists after notice of default and an opportunity to reach an acceptable payment arrangement may result in Central Minnesota Retina Specialists terminating my care upon written notice.

For answers for further questions, please contact **Ashley at 1-888-252-3020.**

I have read and understand the above stated billing policies and my signature below certifies that I agree to these stated billing policies.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_