Retina Consultants, P.C.

WELCOME!

Date: _____ Acct#: _____

Patient Registration Information

Patient Name: _____ Sex: M F Age: _____
(First) (M) (Last)

Birthdate: _____ Patient SS#: _____

Home Address: _____
(Street) (Apt. #)

_____
(City) (State) (Zip)

Home Phone: _____Work Phone: _____Cell Phone: _____

May we leave a message if unable to reach you? (may contain personal information): ___YES ___NO

Email Address: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Insurance Information

	Primary Insurance	**Secondary Insurance**
Ins. Co. Name:	_____	_____
Ins. Co. Address:	_____	_____
Ins. Co. Phone:	_____	_____
Group #:	_____	_____
ID #:	_____	_____
Name of Policyholder:	_____	_____
Policyholder's DOB:	_____	_____
Policyholder's SS#:	_____	_____
Relationship to Patient:	_____	_____
Employer:	_____	_____

*****OVER PLEASE*****

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (SPOUSE, PARENT OR LEGAL GUARDIAN)
(If other than patient)

Name: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Driver's License: _____

Billing Address: _____
(Street) (Apt)

_____
(City) (State) (Zip)

Home Phone: _____ Work #: _____Cell #: _____

ASSIGNMENT OF BENEFITS

I request payment of authorized Medicare and/or Insurance carrier benefits be made on my behalf to Retina Consultants for any service furnished to me by Retina Consultants' physicians. I authorize my physician to release to Medicare and/or my Insurance carrier(s) any information needed to determine these benefits or the benefits payable for related services. **I agree to provide all referrals as required by my insurance carrier(s)**. I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days as a result of incorrect insurance information provided by me (not errors on part of provider claim submission) will become my financial responsibility. I understand any unpaid balances and non-covered services are my financial responsibility. Retina Consultants reserves the right to charge a $25.00 service fee for any unpaid balances including co-pays and deductibles that are due at the time of service. I understand I will be charged a missed appointment fee of $50.00 per visit should I fail to provide 24 hours notice of cancellations or rescheduling. I also understand I will be charged a $35.00 fee for any returned check. Should my account be turned over to a collections agency, I understand that I will be charged for all collection and or attorney and court fees.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: _____ *Date*: _____

Signature: _____ *Date*: _____

Signature: _____ *Date*: _____

Signature: _____ *Date*: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Authorize third party to verify insurance benefits and eligibility.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: _____ *Date*: _____