Patient Registration Information

Date:__________________

Patient Name:____
(*Last*) (*First*) (*MI*)

Street Address____ **Apartment #**__________________

City____ **State**_____________ **Zip**________________

Sex ________**Birth Date**________________ **Age** ___________ **Marital Status**_______________________

Language______________________________**Race**________________**Ethnicity**____________________

1. **Preferred Phone #**____________________ **Home** **Cell** **Work** **(Circle Choice)**
2. **Preferred Phone #**____________________ **Home** **Cell** **Work** **(Circle Choice)**

E-Mail Address:_________________________ **Social Security #**_________________________________

Referring Physician____
(*Name*) (*Phone*)

Primary Care Physician____
(*Name*) (*Phone*)

Please provide us with the names of other doctors that are sharing in your care:

Name:_______________________________________ **Location:** _________________________________

Name:_______________________________________ **Location:** _________________________________

Name:_______________________________________ **Location:** _________________________________

Allergies to Medications: ____

Pharmacy Name:_______________________________________**Location**_________________________

Phone: (_____)______________________

Person to notify in case of emergency: ____

Emergency Phone # (_____)_____________________**Relationship**: _____________________________

*********************** **Employer Information** ******************************

Do you work? (*circle one*) YES NO **Does your spouse work**? (*circle one*) YES NO

Your Occupation: ____

Your Employer: ____

****************************** **Insurance Information** ******************************

Name of person responsible for bills: ____

Address: ____**Phone#** (_____)______________________

Relationship to Patient: ____

Primary Insurance: ________________________________ **Co-Pay**: ____________________________

Policy #: ____**Group #**: ______________________________

Subscribers Name:_______________________________ **Relationship to Patient**: __________________

Secondary Insurance: ____

Policy #: ____**Group #:** _____________________________

Subscribers Name: _______________________________**Relationship to Patient**: __________________

IF YOUR PRIMARY OR SECONDARY INSURANCE IS THROUGH YOUR SPOUSE'S EMPLOYMENT OR YOUR PARENT'S EMPLOYMENT, PLEASE PROVIDE US WITH THEIR:

Name:____

Address: ____

Date of Birth: ________________________ **Social Security #** ____________________________________

RETINAL AND OPHTHALMIC CONSULTANTS, P.C.
General Policies and Release of Information

Please read the following very carefully. By reading and signing this document you agree to adhere to the subject of each item.

INSURANCE REFERRALS AND FINANCIAL RESPONSIBILITY

It is my responsibility to provide Retinal and Ophthalmic Consultants, P.C. with my current insurance cards and any referrals that are necessary. I understand that I am financially responsible for all outstanding balances that may include deductible, co-insurance, co-pay and/or services not covered by my insurance. **In addition, any balance due is to be paid in full no more than six months from the date the claim has been paid by my insurance. Failure to pay my balance due in full in a timely manner could result in my account being turned over to Collections.** The extent of my financial responsibility for all covered services may be limited by the contractual relationship with my insurer.

ASSIGNMENT OF BENEFITS

I authorize payment of medical and/or surgical benefits for services provided, including benefits to which I am entitled, to Retinal and Ophthalmic Consultants, P.C. This assignment will remain in effect until revoked by me in writing.

RECORD RELEASE

I authorize release of my complete medical records to or from other doctors who share in my care, my insurance companies (and their intermediaries or carriers), and to my attorney. **I understand that records may not be released to an attorney or myself if there is an outstanding account balance.** This release includes information that may be considered sensitive, such as but not limited to present or past HIV status, sexually transmitted diseases, abortions, hepatitis, alcohol use or psychiatric treatment. A photocopy of this assignment and authorization is to be considered as valid as an original.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Retinal and Ophthalmic Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. I reserve the right to review Retinal and Ophthalmic Consultants' Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures.

I agree that I may be called at any of the telephone numbers provided including my mobile phone. This includes automated calls. My telephone number will only be used by practice personnel and services affiliated with the practice.

Acknowledgment of Use and Disclosure of Protected Health Information

I authorize Retinal and Ophthalmic Consultants, P.C. (ROC) to use or disclose information regarding my medical condition and related to the individual(s) listed below. I may revoke or terminate this authorization by submitting a written revocation to ROC, Attn: Privacy/Compliance Officer.

____

Individual Relationship Phone # Date

____

Individual Relationship Phone # Date

RETURNED CHECKS

I understand that if for any reason a check is returned for non-payment, I will be charged a $25.00 returned check fee. My insurance company will not cover this fee.

PUPIL DILATION

I understand that my vision may be blurry after my examination, testing or treatment. Retinal and Ophthalmic Consultants recommends that you do not drive after your appointment - please arrange for transportation.

PHOTOGRAPHS AND OTHER IMAGES

As part of my eye care, testing may be performed. This includes but is not limited to ultrasound, photographs, retinal scans and visual fields. Any images, videos or other medical information obtained from these tests are the property of Retinal and Ophthalmic Consultants, P.C. and my doctors. They may use this material for educational and any other purpose as long as my identity cannot be determined or directly implied from these materials.

MINORS/POWER OF ATTORNEY (POA)

All patients who are not 18 or older must have a parent or legal guardian present with them through each appointment. Patients who have a designated power of attorney (POA) for Healthcare and Legal POA must provide documentation of POA. The POA must also provide us with their name, address and phone number.

These policies may change from time to time. Current office policies are available upon request.

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Signature of Patient or POA Print Patient Name Date of Birth Date

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POA name, address and phone (if applicable)

Revised 9-2017