Retina Macula Specialists P.C.

Patient Information

Name ______________________ Date ____________ Record Number ______

Age _____ Birth Date _____ Marital Status (Circle One) Single/ Married/ Divorced/ Widowed

Referred By ____________________ Address ____________________________

Phone: ______________________

Family M.D. ____________________ Address ____________________________

Phone: ______________________

Ref. DX./ Request ____

Decreased Vision? Central/Reading Yes / No Right / Left How Long? ____________

Peripheral Yes / No Right / Left How Long? ____________

Double Vision? Yes / No Right / Left How Long? ____________

Do you see spots/floaters? Yes / No Right / Left How Long? ____________

Do you see flashing lights? Yes / No Right / Left How Long? ____________

Are straight line curves? Yes / No Right / Left How Long? ____________

Veil like sensation? Yes / No Right / Left How Long? ____________

General Medical History:

Diabetes: Yes / No How Long? _________ Glucometer Frequency/ Day _____

Last Reading ________

How is it treated? (Circle One) Insulin Oral Medication Diet and Exercise

Other Endocrine Problems (thyroid) Yes / No How Long? ___

Chronic Fever, Unexplained Weight Loss/Gain, Fatigue Yes / No How Long? ___

Heart Disease (chest pain, irregular heart beat, heart attack) Yes / No How Long? ___

High Blood Pressure (hypertension) Yes / No How Long? ___

Respiratory (shortness of breath, asthma, wheezing, emphysema) Yes / No How Long? ___

Gastrointestinal (heart burn, abdominal pain, diarrhea, vomiting) Yes / No How Long? ___

Integument (skin, rashes, excessive dryness, skin cancer) Yes / No How Long? ___

Ears/ Nose/ Throat (hearing loss, sinus, throat problems) Yes / No How Long? ___

Genitourinary/Dialysis (kidney failure, blood in urine, pain) Yes / No How Long? ___

Bones, Joints, Muscles (arthritis, joint pain, swelling) Yes / No How Long? ___

Neurologic System (numbness, stroke, headaches, paralysis) Yes / No How Long? ___

Hematopoietic/Lymphatic (lymph/blood disorders, sickle cell) Yes / No How Long? ___

Allergic/Immunologic (lupus and sjogrens) Yes / No How Long? ___

Psychiatric (depression, anxiety) Yes / No How Long? ___

Are you currently pregnant? Yes / No ___
How many months? ___

Do you have any drug or food allergies? Yes / No If yes, please list

____

Past Hospitalizations/ Surgery/ Major Illnesses/ Injuries ___________________________

____

____

Do you take any medications? Yes / No If yes, please list

____

____

____

Do you use any eye medications? Yes / No If yes, please list

____

____

____

Eye History:

1) Glaucoma Yes / No Right / Left Year _____

2) Trauma/Injury Yes / No Right / Left Year _____

3)Cataracts Yes / No Right / Left How Long? _____

4) Surgery Yes / No Right / Left Year _____

Eye Surgery or laser Treatment:

Retinal Detachment Yes / No Right / Left How Long? ______________________

Vitrectomy Yes / No Right / Left How Long? ______________________

Freezing Treatment Yes / No Right / Left How Long? ______________________

Laser Treatment Yes / No Right / Left How Long? ______________________

Family and Social History

Do you smoke? Yes / No Packs/Day __________ Do you drink alcohol? Yes / No

Drinks Daily ______________

If employed-Occupation __________________________ Hours Per Week _______________

Family History: Blindness Yes / No Cataract Yes / No

Retinal Detachment Yes / No Macular Degeneration Yes / No

Glaucoma Yes / No Diabetes Yes / No

If yes to any of above, please explain ____

Health Status of parents: Mother ___________________ Father _______________________

Sisters/Brothers _____________________ Children _____________________________

Comments: ____

Reviewing Technician: _______________________ Doctor: __________________________

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. ________________________________ and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________ ______________

Patient (or person authorized to sign for patient) Date

______________________________ ______________

Witness Date

Retina Macula Specialists P.C

Patient Registration/ Insurance Information
(Please Print)

Date:_______________

Patient Name: ___________________________________ Age: ______ Male: ___ Female:__

Date of Birth: __________________________

Address:____________________________ City, State, Zip:___________________________

Home Phone: ________________________ Cell Phone: _____________________________

Occupation: ___________________________Employer: _______________________________

Work Phone: ___________________________Social Security #: __________________________

Marital Status: Single / Married / Divorced / Separated / Widowed
(Please Circle Marital Status)

Spouse's Name: ___________________________ Social Security #: ____________________

Spouse's Date of Birth: _________Spouse's Employer: ______________________________

Nearest Friend/Relative to notify in case of emergency:___________ Phone: ______________

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Patient Referred By: ____

Address/ City ________________________________Phone:____________________________

Family Physician: ____

Address/ City ________________________________Phone:____________________________

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PRIMARY INSURANCE COMPANY _________________________ Phone ______________

Address __________________________________ Policy Holder's Name ______________

Policy Number: ___________ Employer Name ___________________________________

Relationship to patient ____________ Date of Birth _______________________________

SECONDARY INSURANCE COMPANY ___________________ Phone # _______________

Address __________________________ Policy Holder's Name _____________________

Policy Number: ________ Employer Name ___________________________________

Relationship to patient ____________ Date of Birth _______________________________

PREAUTHORIZATIONS: ____

() I certify that I am not enrolled in an H.M.O., Clinic or similar insurance organization. I understand that if I do belong to an HMO or similar insurance organization, and for that reason medicare and/or my insurance refuses to pay Retina Macula Specialists for medical services rendered to me, I will be responsible for payment of such medical services.

() Our billing department will submit the appropriate claim to Medicare or your private insurance companies.

() We accept assignment on all Medicare claims. Medicare will only pay 80% of the approved amount. The remaining 20% will be submitted to your supplemental insurance. If you do not have supplemental insurance you will be billed for the 20%. You will also be responsible for any deductibles not met, or any balance not paid by your insurance company.

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If patient is a minor, who is responsible? ___________________________________

Relationship to patient ____

Name of nearest relative or friend NOT living with you:

Name: ____

Address ____

City, State, Zip ____

Relationship to patient _____________________ Phone # _____________________

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If accident, were you injured at: Work / Auto / Other _______________

What happened? ____

Person to contact regarding accident: ___________________________________

Phone: ____

Additional Information: ____

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I have received and understand the above information.

____ ___________________

Patient Signature Date

____ ___________________

Witness Signature Date

Retina Macula Specialists

AUTHORIZATION TO BILL INSURANCE

Since Retina Macula Specialists P.C will bill on my behalf for payment, I authorize payments directly to the physician of surgical and/or medical benefits. I understand I am responsible for any of my portion not covered by my insurance. I also authorize release of information for insurance claim purposes. Copayments, deductible and self-pay patients balances are due at the time services are rendered. I understand all the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Date:________________ Signed X___________________________
Self / Parent / Guardian

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ____, hereby give my consent to Retina Macula Specialists P.C to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ___________________________________. (Patient Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be revoked by me.

I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I authorize my health care provider to use an automated telephone system and/or email and to use my name, address, and phone number; the name of my scheduled treatment physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other health related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voicemail system or answering machine.

If you are not the patient, please specify your relationship to the patient.

Signature:______________________________ Date:____________________

Financial Responsibility Statement/Release of Information Authorization

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I hereby assign all medical and/or surgical benefits, to include major medical benefits which I am entitled, including Medicare, private insurance and other health plans to: Retina Macula Specialists P.C., 550 E. Boughton Road, Suite #120 Bolingbrook, IL. 60440 Suite 120. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. In the event that this account is assigned to collections, I agree to pay all cost of collection, including reasonable attorney fees, and interest at the legal rate. By signing this I agree to this financial policy.

Signature: ______________________________ *Date:* ____________________

Payment Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

**Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept cash, checks, money orders, visa, and mastercard.*

**Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor- in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.*

**We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment when you arrive for your appointment.*

**If you have insurance coverage with a plan with which we do not have a prior assignment, we will prepare to send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.*

**All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.*

**For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for the payment.*

**In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.*

**If your insurance is HMO, the patient is always responsible for obtaining their referral from their primary care physician.*

**We request that when giving our practice your insurance information, that you provide the most current and accurate information. Patient is also responsible for informing our office of any changes in personal and insurance information.*

**If these changes are covered under workman's compensation, you must give us the correct employer information and the workers compensation case number.*

I hereby agree to the following terms and conditions:

There is a 1.5% monthly late charge assessed on all balances after 120 days past due. Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee. Also, the undersign agrees to pay a collection fee of 33% of the total owed when sent to collection, all attorney fees and court costs incurred by the creditor. All the information provided is correct.

I have read and understand the above paragraph in its entirety.

Signature ______________________________ Date ____________