ALABAMA RETINA

Patient Registration Form

Patient's Name: _____ SSN: _____ DOB: _____ Gender: _____

Mailing Address: _____ Phone: _____

City:_____ State: _____ Zip:_____ Cell: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Guarantor (if patient is a minor): _____ Relationship: _____

Guarantor's Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Location: _____

Primary Insurance: _____ Phone: _____

Policy ID #:_____ Group #: _____

Policy Holder:_____ DOB: _____

Effective Date: _____ Copay: _____

Deductible: _____ Coinsurance: _____

Notes: _____ Out of Pocket: _____

Representative: _____ Date: _____

I consent to medical examination, treatment, and diagnostic studies advised by the physician. I authorize and assign my insurance benefits be paid directly to the practice. Alabama Retina will offer what they feel, in their medical opinion, is medically necessary for my health care. I understand some services advised by my doctor may or may not be covered by insurance. I understand that I am financially responsible for any outstanding balance and will promptly pay this in full within 30 days of receiving a bill. I understand accounts 90 days past due will be transferred to a third party collections agency and that I will be responsible for any and all fees associated with this transfer. I also authorize Alabama Retina and/or my insurance company to release any information required to process my claims.

_____ _____

Patient or Guarantor Date

ALABAMA RETINA

PAST MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **TODAY'S DATE:** _____

Eye Problems

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Other

_____

_____

_____

☐ None

Eye Medications

Medication name	*Dose*

☐ None

Other Medical Problems

- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Cancer
- ☐ Asthma
- ☐ Rheumatoid Arthritis
- ☐ Other (Include Any Surgical Procedures)

_____

_____

_____

_____

_____

☐ None

Medications (Including Alternative/Herbal)

Medication Name	*Dose*

☐ None

Family Medical History

	Family Member(s):
☐ Glaucoma	
☐ Macular Degeneration	
☐ Hypertension	
☐ Diabetes	
☐ Other	

☐ None

Social History

Smoking ☐ No ☐ Yes

Alcohol ☐ No ☐ Yes

Allergies	***Reaction?***

☐ No Known Drug Allergy

ALABAMA RETINA

REVIEW OF SYSTEMS

PATIENT NAME: _____ DOB: _____ TODAY'S DATE:_____

FOR THE FOLLOWING CONDITIONS, PLEASE CHECK THE SYMPTOMS YOU **CURRENTLY** HAVE:

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Other _____

CONSTITUTIONAL

- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Other _____

EYES

- ☐ Eye Pain
- ☐ Vision Change
- ☐ Floaters
- ☐ Other_____

ENDOCRINE

- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Hair Loss
- ☐ Other _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Changes in Bowel
- ☐ Other _____

GENITOURINARY

- ☐ Burning on Urination
- ☐ Urinary Retention
- ☐ Blood in Urine
- ☐ Other _____

EAR, NOSE, THROAT

- ☐ Hearing Loss
- ☐ Nasal or Sinus Congestion
- ☐ Dry Mouth
- ☐ Other _____

SKIN

- ☐ Rash
- ☐ Itching
- ☐ Skin Sores
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Muscle Aches
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Other_____

NEUROLOGICAL

- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Frequent Headaches
- ☐ Other _____

PULMONARY

- ☐ Wheezing
- ☐ Coughing
- ☐ Difficulty Breathing
- ☐ Other _____

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Other _____

Updated 4/15/2014

☐ **NO CURRENT SYMPTOMS**

ALABAMA RETINA

NOTICE OF PRIVACY, ASSIGNMENT OF BENEFITS & PATIENT CONSENT

Authorization to Release Information:

You have the right to:

- Get a copy of your paper or electronic medical record
- Ask us to correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
  www.hhs.gov/hipaa/filing-a-complaint

By signing at the bottom of the page, I agree to allow Alabama Retina to request or release my information to other healthcare providers, medical institutions, radiology centers, or laboratories, when necessary for my medical care. I also authorize these offices to release my records. I authorize Alabama Retina to use my medical information and photos anonymously for the purpose of teaching or publication. I authorize the release of medical records concerning my treatment to insurance companies and to Medicare.

Assignment of Benefits:

By signing at the bottom of the page, I authorize Alabama Retina to handle my medical claims. I assign my benefits to the practice, allowing it to accept direct payment from my insurance company, including Medicare.

HIPAA Authorization:

I authorize the following person(s) to discuss my medical care and billing/insurance information with the Alabama Retina staff on my behalf. I understand that my health records may contain information related to sexually transmitted diseases, AIDS, HIV, behavioral or mental health services, or treatment for alcohol or drug abuse.

Name _____ Relationship _____

Name _____ Relationship _____

Consent for Treatment:

I authorize the staff of Alabama Retina to perform diagnostic tests to assess and diagnose my condition and authorize the physician to perform treatments if necessary for my condition. By signing below, I indicate that I have read, understand, and agree to the Privacy Notice, Assignment of Benefits, and Consent for Treatment. Dilating drops will be used to get a better view of the inside of your eye. Dilating drops blur the vision and make bright lights more bothersome. Driving will be more difficult after these drops are used, so I should make arrangements not to drive myself

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

_____ _____

Witness's Signature Date

ALABAMA RETINA

PATIENT FINANCIAL RESPONSIBILITY

Alabama Retina understands that medical insurance is complex and we will submit medical claims on your behalf to your insurance company. Please bring proof of insurance to each visit. Some insurance companies arbitrarily select services they will not cover. Any such charges are your responsibility. If there are payment related questions, please contact us.

1. We are required by law to collect co-pay, deductible, and co-insurance at each visit**.**
2. For follow up visits, any existing balances must be paid prior to or at the time of your next appointment. There is a $25 fee on returned checks.
3. Managed Health Care Insurance Plans (HMO,PPO). It is your responsibility to understand your benefit plan, to know if we are in network, and to bring a written referral if one is required. If we are out of network, than you will be billed at out of network rates.
4. **If you do not have insurance, a $200 deposit will be collected at check in for new patients, and a $100 deposit will be collected for return patients**. This is a deposit only and if your treatment costs exceed this amount, the additional balance will be collected prior to treatment.
5. You will receive a statement from our office within 30 days of your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due within 30 days of receiving the statement. If your account is over 90 days late from the date of service, it will be sent to collection agencies and a 33% collections fee will be added.
6. We are participating providers for Medicare. Medicare sets the fee schedule for physicians. Medicare pays 80% of the fee schedule, and the remaining 20%(co-insurance) is the patient's responsibility. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid.
7. The administration fee for medical records requested for personal use is $1.00 per page for the first 25 pages and 50 cents per page after the first 25 pages. The fee for filling out FMLA and other disability paperwork is $40.
8. In order for Alabama Retina to collect any balance you may owe, our collection agents may contact you by text, email, or telephone including your wireless telephone number.
9. **Alabama Retina will not deny emergency care.**

By signing this, I understand that some services may not be covered by my insurance company. I understand that I am responsible for any outstanding balance and will pay this in full within 30 days of receiving the bill.

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

_____ _____

Witness's Signature Date