RETINA SPECIALTY INSTITUTE

Address: 5150 N Davis Highway Pensacola, FL 32503
Toll-Free: 855.5RETINA
Fax: 850.484.5522
retinaspecialty.com

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Health Information Privacy Practices, which provides a complete description of health information uses and disclosures. I understand that I have the following rights and privileges.

The right to review the notice prior to signing this consent
The right to object to the use of my health information for directory purposes
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, Retina Specialty Institute will no longer use or disclose medical information about me for the reasons covered by my written authorization. I understand that Retina Specialty Institute is unable to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me.

I further understand that if I choose to revoke my consent, Retina Specialty Institute may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

By signing this document, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices.

_____	_____	_____
Print Name	Signature	Date

With your permission, Retina Specialty Institute may release your protected health information to a family member, or another person involved in your care or payment for your care.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend, or guardian. Please list below:

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

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Please Print Clearly

Name: _____
Social Security Number: _____
Date of Birth: _____ ☐Male ☐Female
☐ Single ☐ Married ☐ Other: _____

Address: _____
City: _____ **State**: _____ **Zip**: _____
Home Phone: _____
Cell Phone: _____
TEXT MESSAGE ON: ☐ YES ☐ NO
Employer : _____
Work Phone: _____ Ext.: _____
Email Address: _____
Would you like to have access to your medical records/portal? ☐ **YES** ☐ **NO**

If patient is a minor, parent / legal guardian must fill out information below:
Parent Name: _____
Parent DOB : _____
Parent Address : _____
City: _____ State: _____ Zip: _____
Parent Signature: _____

Referred by: _____
☐ PLEASE CHECK IF SELF REFERRED
Family Doctor: _____
☐ PLEASE CHECK IF NO FAMILY DOCTOR

Preferred Language: _____
Ethnicity: ___ Hispanic Origin ___Non-Hispanic Origin
Race: ☐ American Indian or Alaskan Native
☐ White ☐ Asian ☐ Black / African American
☐ Native Hawaiian or Pacific Islander

Emergency Contact 1:
_____
Emergency Phone: _____
Relationship: _____

Emergency Contact 2:
_____
Emergency Phone: _____
Relationship: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my Dependent) have insurance coverage with the carrier(s) given to the front desk staff and assign directly to Retina Specialty Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

If your insurance is an HMO, your HMO requires that your primary care doctor provide a referral to the physician who is providing your ophthalmology care. It is your responsibility to obtain authorization in advance of your appointment (at least 24 hrs.). Your doctor may mail/fax it to our office or you may bring it to your visit. Contact us if you require any assistance in obtaining the authorization. We will be happy to help in any way possible. If an authorization is not obtained from your HMO prior to the delivery of care, we will expect you to accept financial responsibility for any charges. You will be sent a bill from the billing office for physician services provided to you. I have read the statement above and I understand that I will be billed and am responsible for payment for the professional and facility fees for services provided to me in the event that my HMO does not authorize these services.

Signature of Patient: _____ Date:_____

Responsible Party Signature: _____ Relationship to Patient: _____

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Medical History Questionnaire

Name: _____ **DOB**: _____ **Referring Doctor**: _____

List any medications you routinely take: _____

_____

_____

Allergies to medications: _____

Do you **presently** have any of the following symptoms?

	YES	NO
Blurred Vision	☐	☐
Chest Pain	☐	☐
Diarrhea	☐	☐
Fatigue	☐	☐
Headache	☐	☐
Dizziness	☐	☐
Pain in Joints	☐	☐
Paralysis of Extremities	☐	☐
Shortness of Breath	☐	☐
Runny Nose	☐	☐
Sore Throat/Cough	☐	☐
Bloody Stools	☐	☐
Fever	☐	☐
Nausea/Vomiting	☐	☐
Pain with Urination	☐	☐
Frequent Urination	☐	☐
Rash	☐	☐
Sudden Vision Loss	☐	☐

Any diseases in the family? If "YES," please indicate relationship to you.

	YES	NO
Blindness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Attacks	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

Indicate your **past** or **present** medical history:

	YES	NO
Blindness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Cardiac / Vascular Disease	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
High Blood Pressure	☐	☐
Kidney Stones	☐	☐
Stomach Ulcer	☐	☐
Asthma / Emphysema	☐	☐
AIDS / HIV	☐	☐

List **any surgeries** you have had in the past:

_____

_____

_____

_____

Do you smoke? YES ☐ NO ☐ Pack(s) a day: _____

If no, did you smoke in the past? YES☐ NO ☐

Do you drink alcohol? YES ☐ NO ☐

Number of glasses a day: _____

Do you drive? YES ☐ NO ☐

Other important information:_____

_____

Patient Signature_____Date_____

Doctor Signature_____ ☐ **Reviewed information with patient** Date_____

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Retina Specialty Institute. We are committed to the treatment, preservation, and advancement of your retina care. Please understand that payment of your bill is considered part of your retina care. The following is a statement of our **Policy**, which we require that you read and sign before being seen by one of our physicians.

Your Responsibility:

You are financially responsible for the services we provide to you. As such, we require that the patient or legal guardian to either pay or arrange for payment at time of service. As a courtesy to you, we will file a claim to your insurance plan(s). Please remember that your insurance benefits are a contract between you and your insurance carrier. If there is a discrepancy with payment of our claims, we may look to you for assistance in expediting our claims in a timely manner.

Non-Covered Service Condition

Since we are a specialty practice, some procedures that may be performed in your treatment plan could be deemed non- covered by your insurance plan. In the event that these services are determined non-covered, it is your responsibility to pay for the services rendered. Our patient financial counselors are available to review these out-of-pocket expenses with you prior to services being rendered.

Prior Balance

Patients with a balance from prior dates of service will be required to pay that balance in full before being seen by our physicians. If the prior balance cannot be paid in full, you will be asked to speak to our patient financial counselors to make payment arrangements based on our payment policy prior to being seen by one of our physicians.

Self-Pay Patients

Patients that have no insurance or who elect to pay fee-for-service, will be extended a discount from charges. You will be expected to pay for the balance in full at the time of service.

Returned Checks

We will assess a fee on all checks that have been returned by our bank for "non-sufficient funds" per applicable state law. Payment of this fee must be made prior to your next appointment.

Collection Agency

Prompt payment of patient balances is expected per the terms of this agreement. We will use an outside collection agency for patient balances as we deem necessary. Failure to resolve outstanding patient balances may result in discharge from care by our physicians. Prior balances must be resolved before the practice will provide new services.

I have read and understand the financial policy of Retina Specialty Institute. I agree and understand the terms and conditions of this policy, and agree that any questions I have, have been answered by the patient financial counselors to the best of my understanding.

_____ _____

Signature of Patient or Guardian of Minor Date

_____

Print Name of Patient