NC RETINA ASSOCIATES

PATIENT REGISTRATION FORM

First Name ______________________ **Middle Name** ______________________

Last Name ______________________ **Date of Birth** ______________________

Mailing Address: Street ______________________ Apt/Ste #__________

City ______________________ State __________ Zip __________

Phone Numbers: Cell Phone ______________________ Home ______________________

⬜ Check here if you **DO NOT** authorize NC Retina to leave a message containing appointment information.

Email Address ______________________

Social Security # ______________________ **Patient Employer Name** ______________________

Gender *(Please circle)*
Male / Female

Marital Status *(Please circle)*
Single / Married / Divorced / Separated / Widowed

Race/Ethnic Group *(Please circle)*
American Indian / Alaska Native / Asian / Black or African American / Chinese / Filipino / Hispanic or Latino
Japanese / Korean / Native Hawaiian / Pacific Islander / Other / Unknown / White / Decline to Provide

Emergency Contact: Name ______________________ Number ______________________

Relationship to you ______________________

Primary Care Physician/General Practitioner ______________________

City / State ______________________ Phone Number ______________________

GUARANTOR INFORMATION

⬜ Check here if the **PATIENT** is financially responsible.

- If anyone **OTHER THAN THE PATIENT** is financially responsible, then please fill out the information below.

First Name ______________________ **Middle** __________ **Last** ______________________

Date of Birth ______________________ **Social Security #** ______________________

Mailing Address: Street ______________________

City ______________________ State __________ Zip __________

NC RETINA ASSOCIATES

FINANCIAL POLICY

Thank you for choosing North Carolina Retina Associates (NC Retina). We are committed to providing you with the highest quality medical eye care possible in an efficient and cost-effective manner. In order to service your insurance needs, we require your understanding of our office financial policy.

NC Retina will file your medical claims as a courtesy, to all insurance companies we are contracted with. Although we make every effort to verify your coverage, NC Retina will not guarantee the information given to us by your insurance company is correct. If we are given incorrect insurance information either by the patient or an insurance company that delays payment beyond the limit to file the claim, you will be responsible for the charges.

PATIENT RESPONSIBILITIES: ______

• At each visit, you will provide your current and correct medical insurance information. You will be asked to show your current insurance card(s) and drivers license.
• You will notify a receptionist of any demographic changes such as address and phone number.
• Patients are responsible for understanding their own coverage, co-pays, deductibles, referrals or other insurance requirements.
• If your plan requires a referral to see a specialist, you must ensure the proper referral is in place prior to your appointment. Failure to obtain a referral will result in you being financially responsible for all services rendered which must be paid at time of service.
• Your co-pay is expected at the time of service.
• Upon processing of your claim(s) through insurance(s) on file, any remaining balances will be reflected in a statement mailed to you.
• If payment cannot be made in full, you will agree to enter into a payment plan and make consecutive monthly payments.
• In the event of a claim denial, unrelated to billing errors, you may be asked to contact your insurance company to assist in denial resolution. Patient assumes full responsibility of payment if you fail to comply with the assistance request.

SELF PAY POLICY ______

Each visit, we require a partial payment/deposit of $100.00 prior to you receiving medical care from our physicians. Any remaining balances will be reflected in a statement mailed to you.

OUT OF NETWORK INSURANCE POLICY ______

NC Retina will not file claims to insurance companies we are not contracted with. If you wish to receive medical eye care from our physicians, you will be considered a self pay patient and the self pay policy will apply to you. If you provide written confirmation to us regarding your out of network benefits, we will provide you with the documentation needed for you to file your claim for personal reimbursement.

WORKERS COMPENSATION POLICY ______

In order for NC Retina to file a claim with your workers comp or other liability carrier, you must provide complete billing information. Without this information, we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. You will be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. NC Retina will not bill attorneys for medical expenses.

NC RETINA ASSOCIATES

PATIENT ASSISTANCE PROGRAMS ______
We often enroll qualified patients in grants and assistance programs to help pay for the cost of injectable drugs. These programs often have a copay amount similar to an insurance copay. You are responsible for paying this copay on days you receive an injection. Also note these programs open and close at will. If the foundation runs out of funds, you will be responsible for any unpaid drug coinsurance.

AUTHORIZATION TO RELEASE INFORMATION ______
I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to NC Retina any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS ______
I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to NC Retina for any services provided to me. I authorize any holder of medical information about me to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT ______
If my insurance has a contract with NC Retina I am not responsible for amounts the practice has agreed to write-off per the contract. If my insurance does not have a contract with NC Retina I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorneys' fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

AGREEMENT TO PAYMENT POLICY ______
I acknowledge that I reviewed NC Retina financial policy and agree to the terms of payment due.

____ ________________________

PRINTED NAME OF PATIENT **TODAY'S DATE**

____

PATIENT SIGNATURE

If applicable, please complete the section below:

Personal Representative (please print) ____________________________________

Personal Representative Signature ______________________________

Relationship to patient _________________________ Date____________________

NC RETINA ASSOCIATES

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize NC Retina to release my medical, billing, and/or appointment information to:

RELATIONSHIP		NAME OF AUTHORIZED PERSON	INFORMATION TO RELEASE
Spouse	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment
Child	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment
In-law	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment
Caregiver	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment
Parent	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment
Other	☐ Yes ☐ No	______________________________	☐ Medical ☐ Billing ☐ Appointment

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do so by written notification. I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

A copy of the Notice of Privacy Practices from NC Retina has been made available for me to view.

____ ____________________________

PRINTED NAME OF PATIENT **TODAY'S DATE**

____

PATIENT SIGNATURE

If applicable, please complete the section below:

Personal Representative (please print) ____________________________________

Personal Representative Signature _______________________________

Relationship to patient _________________________ Date____________________

For Office Use Only

We were unable to obtain the acknowledgment for the following reason:

☐ An emergency existed and a signature was not possible

☐ Patient refused to sign

☐ Unable to communicate with patient

☐ Other: ____________________

NAME:____ DOB:__________________ DATE:__________________

OCULAR HISTORY

Do you take AREDS2 eye vitamins? YES NO

Do you take any other eye vitamins? YES (Please List)_______________________NO

Please list any Eye Drops you are CURRENTLY using and **SPECIFY WHICH EYE.**

____

____

____

____

Previous Eye Surgeries:

____

____

Previous Eye Trauma:

____

Other Eye Diseases:

____

MEDICAL HISTORY

Have you had your Flu Vaccine this season? YES NO Date: ______________________________

Have you had a Pneumonia Vaccine within the last 5 years? YES NO Date:____________________

Do you have Diabetes?

- ❑ TYPE I
- ❑ TYPE II

Approximate Year Diagnosed:________________Last Hemoglobin A1C:____________________

Physician Managing Diabetes:____

Please check all that apply:

- ❑ Seasonal Allergies
- ❑ Asthma
- ❑ Thyroid Disease
- ❑ Acid Reflux
- ❑ High Blood Pressure
- ❑ Elevated Cholesterol
- ❑ Arthritis
- ❑ Hearing Loss
- ❑ Cancer
- ❑ History of Stroke
- ❑ History of Heart Attack
- ❑ COPD

Other Medical Conditions not listed above:

____

____

____

SURGICAL HISTORY

Please list any prior surgeries and dates below:

____

____

____

____

NAME:________________________________DOB:_______________DATE:_______________

MEDICATIONS

Preferred Pharmacy:____

Do you take a blood thinner? YES NO

- ❑ Aspirin
- ❑ Xarelto/Rivaroxaban
- ❑ Eliquis/Apixaban
- ❑ Warfarin/Coumadin
- ❑ Other:____

Please list ALL medications and vitamins you are CURRENTLY taking with dosages and instructions.

____
____
____
____
____
____
____

Drug Allergies:

Are you allergic to Iodine? YES NO Are you allergic to LATEX? YES NO

Other:____
____

FAMILY HISTORY

- ❑ Blindness Relationship:____
- ❑ Retinal Detachment Relationship:____
- ❑ Macular Degeneration Relationship:____
- ❑ Glaucoma Relationship:____
- ❑ Diabetes Relationship:____
- ❑ Cancer Relationship:____
- ❑ Stroke Relationship:____
- ❑ Heart Disease Relationship:____

SOCIAL HISTORY

Are You:

- ❑ Not Working/Disabled
- ❑ Retired
- ❑ Working

Occupation:_______________

Tobacco Use:

- ❑ NEVER SMOKER
- ❑ CURRENT SMOKER
- ❑ FORMER SMOKER

Date Quit:___________

Alcohol Use:

- ❑ NONE
- ❑ Occasional/Social
- ❑ 1-2 Drinks Daily
- ❑ 3-4 Drinks Daily

Illicit Drug Use: YES NO If Yes, Please Explain:_______________________________________

Are you pregnant or trying to conceive? YES NO

Have you been exposed to a Sexually Transmitted Infection? YES NO ______________________