FLORIDA RETINA
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FOR OFFICE USE ONLY

ACCOUNT #: _____

OFFICE LOCATION: _____

DATE: _____

NAME: _____
LAST FIRST MIDDLE

SEX: _____ / _____ **BIRTHDATE:** _____ / _____ / _____ **AGE:** _____
male female mo. day year

ETHNICITY: _____ Hispanic/Latino _____ Non-Hispanic/Latino

RACE: _____

PREFERRED LANGUAGE: _____

ADDRESS: _____

LOT/APT#: _____

CITY, STATE: _____

ZIP: _____

SOCIAL SECURITY NUMBER: _____

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE (HOME): _____

PHONE (CELL): _____

IF YOU ARE A DEPENDENT ON THIS POLICY, PLEASE PROVIDE THE FOLLOWING FOR THE PRIMARY POLICY HOLDER:

NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED.

_____

SIGNED (INSURED OR AUTHORIZED PERSON)

Single ( ) Married ( ) Divorced ( ) Widow ( )

PHONE: (HOME) _____ / _____
area code

(CELL/BUSINESS) _____ / _____
area code

EMAIL ADDRESS: _____

FAMILY DR: _____

ADDRESS: _____

PHONE: _____

REFERRING DR: _____

ADDRESS: _____

PHONE: _____

IS PATIENT IN A SKILLED NURSING FACILITY? YES NO

IS PATIENT IN A REHAB FACILITY? YES NO

IF YES, PLEASE PROVIDE:

FACILITY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

PLEASE PROVIDE INSURANCE CARD(S) SO THAT RECEPTIONIST CAN MAKE A COPY. THANK YOU.

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Name: _____ DOB: _____ Today's Date: _____

Personal medical history		Check if YES	Insulin dependant		Type 1	Type 2	Year diagnosed
Endocrine:	Diabetes		Yes	No			
	Thyroid disease						
	High cholesterol						
Cardiovascular:	Heart disease						
	High blood pressure		How many years? _____				
Oncology:	Cancer		Please specify: _____				
Immunologic:	Lupus						
	Hepatitis						
Respiratory:	COPD						
	Asthma or emphysema						
Musculoskeletal:	Arthritis						
Neurologic:	Multiple sclerosis						
Constitutional:	Weight loss/gain						
Gastrointestinal:	Ulcers						
Genitourinary:	Kidney disease						
HENT:	Hearing loss						
Integumentary:	Skin condition		Please specify: _____				
Psychiatric:	Anxiety						
	Depression						

Other (please specify): _____

Major surgeries: _____

Eye surgeries: _____

Social history	Yes/No	How much?	# day	# week	Occas.	Former
Do you drink alcohol?						
Do you smoke?						

	Yes	No
History of blood transfusion?		
Received a pneumonia vaccine?		
Have you had a flu shot?		
Do you have a living will?		

Family medical history	Yes	No	Mother	Father	Brother	Sister	G-parent
Blindness							
Macular degeneration							
Glaucoma							
Retinal Detachment							
Cancer							
Diabetes							
Heart disease							
High blood pressure							

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CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

NAME: _____ DOB: _____ DATE: _____

PHARMACY: _____ PHARMACY PHONE #: _____

DRUG ALLERGIES: _____

DRUG NAME (PLEASE PRINT)	DOSAGE	FREQUENCY	ROUTE (oral, nasal, IM, drops, topical, suppository)	ADD OR DISCONTINUE DATE

FOR OFFICE USE ONLY:

Updated by:	Date:	Updated by:	Date:	Updated by:	Date:

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LIFETIME AUTHORIZATION FOR INSURANCE/MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Florida Retina Institute.

I authorize any holder of medical or other information about me to release to the health care financing administration and/or it's agents information needed to determine these benefits for related services.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Florida Retina Institute for any services for me by a physician or supplier. I authorize any holder of medical information about me to release to any of my insurance companies any information needed to determine these benefits payable for related services.

I hereby authorize payment directly to Florida Retina Institute of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denied as a result of preexisting conditions.

I permit a copy of this authorization to be used in place of the original.

Regulations pertaining to Medicare assignment of benefits apply.

I further authorize Florida Retina Institute to fax/electronically transmit the results of my evaluations to my referring physician if appropriate.

SIGNATURE: _____

PARENT/GUARDIAN: _____

DATE: _____

40 YEARS

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I have been given the opportunity to read the Florida Retina Institute's Notice of Privacy Policy concerning how my personal information may be used. I give my permission to use my personal information in accordance with this policy. This signature sheet will remain in the patient's chart as record of acceptance and the Notice of Privacy Practice is for the patient (or patient's representative) to keep his/her records.

Patient's Name: _____

SIGNATURE (Patient of Authorized Representative): _____

Relationship to Patient if other than self: _____

Date: _____

* You may receive a copy of Florida Retina Institute's Notice of Privacy Policy upon request at check-in. Thank You.

AUTHORIZATION TO RELEASE INFORMATION

Without your express written permission, Florida Retina Institute cannot discuss your treatment or billing information with anyone but you, the patient. If you want our office to discuss your treatment and billing information with a **spouse, family member, care giver, etc.**, please list their names below. Please notify us in writing of any changes to the list you complete below:

_____

_____

SIGNATURE: _____ DATE: _____

Form #12

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FINANCIAL PRACTICES DISCLOSURE

Welcome to Florida Retina, dba Florida Retina Institute. Our practice participates in many medical insurance plans. If we are participating providers for your plan, we will file the claim on your behalf. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, most major credit cards, and Care Credit. Please be sure to provide us with your most current insurance card(s) at each visit and advise us of any changes. Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employee ID as the subscriber number. If you are not the primary cardholder please make sure you give us the correct subscriber (employee) ID number at the time of your visit.

All of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Copayments/Coinsurance/Deductibles: If your plan requires that you pay a copayment, deductible or coinsurance, you are required to pay at the time services are rendered.

Self-Pay Patients: Patients with no insurance are expected to pay at the time of service for all care rendered.

Authorizations/Referrals: Many insurance plans require a referral/authorization for office visits and/or procedures. You will need to obtain this referral/authorization from your primary care or referring physician prior to being seen in our office. If you are having surgery we will assist in getting pre-certification or prior approval for your procedure.

Non-Covered Services: On occasion, we may render a service that is not covered by your insurance plan. We make every effort to inform you of this in advance. Any non-covered services will become due and payable by you upon notice from your insurance carrier.

Out-of-Network Services: We make every effort to verify your plan benefits prior to your appointment. In the event that you obtain services by a physician who is not a participating provider with your plan, the amount will become due from you. Please always make sure that the doctors you are treating with participate with your plan.

Affordable Care Plans/Healthcare Exchange: If you have an Affordable Care Plan, you are responsible for paying your healthcare insurance premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, you will be held liable for the amount of the bill for the services rendered by our physicians. This amount will be due in full upon notice.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of my personal information, whether medical or otherwise, to release to any third party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician services to the physician or organization furnishing the services. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient/Legal Guardian Signature: _____

Printed Name: _____

Date Signed: _____

11/15/16 BG

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