



Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: **M** **F**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Preferred: Home Cell Email

Email: \_\_\_\_\_ Language: \_\_\_\_\_

Race (Optional): \_\_\_\_\_ Ethnicity (Optional): \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

***I authorize my emergency contact to have access to patient health information:*** Yes No

**Parent / Legal Guardian / POA Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured Name and DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured Name and DOB: \_\_\_\_\_

**Patient Doctor Information**

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care

operations. I accept full financial responsibility for services rendered by Advanced Retina & Eye Cancer Center and agree to pay all reasonable collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Advanced Retina & Eye cancer Center should they elect to receive such payment. My signature below indicates that I have fully read and understand the written authorization.

My signature below indicates that a copy of The Privacy Policy for Advanced Retina & Eye Cancer Center has been made available to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment policies.

### **Payments**

An insurance plan is a contract between a patient and their health insurance company. It is the patient's responsibility to know their benefits and the limits of their coverage. **We require that patient payments, to include co-pays, coinsurance, and deductibles, be made at the time of service.** For your convenience, we do accept checks, money orders, debit cards, and all major credit cards.

### **Self-pay Accounts**

Self-pay accounts are for patients without insurance coverage, as well as patients covered by insurance plans in which our office does not participate. It is the patient's responsibility to know if our office is participating with their health plan. Self-pay patients will be required to pay up front for all services performed.

### **Workers' Compensation**

It is the patient's responsibility to provide our office staff with contact information regarding a workers' compensation claim, at the time of service. Any charges denied by workers' compensation will then become the patient's responsibility.

### **Overdue Balances**

When a balance is due, the patient will be sent three statements, one per month. **Each month that the balance remains unpaid, a \$15.00 late fee will be added to the balance.** If payment in full has not been received within the 90-day period, the patient will be dismissed from the practice and the balance may be turned over for collections. Unpaid balances which are sent to collections will incur additional fees, as the patient will be held responsible for all collection costs.

I hereby authorize Advanced Retina & Eye Cancer Center to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Advanced Retina & Eye Cancer Center. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financially responsible for all charges not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

### **No- Show Fee**

**Please note that our office has a \$50 no-show fee for missed appointments without prior notice. We appreciate your understanding and cooperation.**

*I have read and understand these payment policies and agree to abide by the guidelines.*

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Patient/Guardian Signature

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Date



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

**Ocular History:** (circle any of the following which you have experienced)

Macular degeneration	Retinal detachment	Retinal tear
Loss of vision	Distorted vision	Corneal disease
Floaters and/or flashes	Eye pain	Blurred vision
Poor night vision	Eye trauma	Diabetes in eyes
Loss of peripheral vision	Glaucoma	Melanoma in eyes

Other: \_\_\_\_\_

**Medical History:** (circle to indicate a personal history of any of the following)

Diabetes	High Blood Pressure	Lung disease / asthma
Cancer	Thyroid disease	Arthritis
Stroke	Heart disease / attack	Depression

Other: \_\_\_\_\_

**Surgical History:** (include any eye surgeries)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Medications:** (include any eye drops)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies to medications:** \_\_\_\_\_

**Social History:**

Do you currently smoke? YES NO If yes, how much? \_\_\_\_\_ If no, have you previously? \_\_\_\_\_

Do you drink alcohol? YES NO If yes, how often? \_\_\_\_\_ How many drinks? \_\_\_\_\_

**Family History:** (circle to indicate a family history of any of the following)

Diabetes	High blood pressure	Retinal detachment	Cancer	Heart disease / attack
Glaucoma	Stroke	Macular degeneration	Melanoma in eyes	Other

**Review of Systems:** (circle any symptoms you are experiencing **TODAY**)

<b>Eyes</b>	Redness	Eye pain	Sudden loss of vision	Excessive tearing	Sudden change of vision	
<b>Constitutional</b>	Fever	Weight loss	Weight gain	Night Sweats		
<b>Ear, Nose, Mouth &amp; Throat</b>	Congestion	Ear ache	Loss of hearing	Sinus pressure	Nose bleeds	
<b>Cardiovascular</b>	Chest pain	Irregular heartbeat	Rapid heartbeat			
<b>Respiratory</b>	Shortness of breath			Wheezing		
<b>Gastrointestinal</b>	Diarrhea	Constipation	Vomiting	Nausea	Heartburn	Abdominal pain
<b>Genitourinary</b>	Incontinence		Painful urination		Blood in urine	
<b>Integumentary</b>	Rash		Dermatitis		Wart	
<b>Neurological</b>	Numbness	Weakness	Loss of balance		Headache	
<b>Musculoskeletal</b>	Swelling	Joint stiffness	Joint pain	Muscle aches	Cramps	Muscle weakness
<b>Hematologic / Lymphatic</b>	Anemia	Easily bruise and/or bleed		Nonhealing wounds	Swollen lymph nodes	
<b>Allergic / Immunologic</b>	Itching	Hay fever	Sneezing	Seasonal allergies		Hives
<b>Psychiatric</b>	Anxiety	Depression	Memory loss		Difficulty sleeping	
<b>Endocrine</b>	Excessive thirst		Excessive urination		Palpitations	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Email and Text Messaging Consent Form

We now provide our patients with the option to participate in our online patient communication system.

### PLEASE MARK THE FOLLOWING:

/ **consent to receiving appointment confirmations via email.** I understand I can withdraw my consent at any time.

My email address is: \_\_\_\_\_

/ **consent to receiving appointment reminders via text.** I understand I can withdraw my consent at any time by replying STOP as well as informing front office staff {Text messaging or data rates may apply and Advanced Retina & Eye Cancer Center is not responsible for any fees.}

My cell phone number is: \_\_\_\_\_

/ **consent to receiving appointment reminders via voice calls.** I understand I can withdraw my consent at any time.

My phone number is: \_\_\_\_\_

/ **DO NOT consent to receiving any information via email, text or voice calls.** I understand I will not be reminded of my appointments.

Please sign below to indicate that you agree to allow us to use this information in providing your services. You may choose to discontinue your participation in our online communications system at any time by notifying front office staff

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_