

DALLAS RETINA CENTER

PATIENT INFORMATION

Today's Date: _____

First Name _____ Last Name _____ MI _____

Date of Birth _____ Age _____ Marital Status: S / M / D / W Sex: Male / Female

Race _____ SS# _____ Email _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Employer Name _____ City _____ State _____

Referred by: Dr. _____ / Google / Other: _____

Primary Care Physician: _____ City: _____

Pharmacy: _____ Intersection: _____ City: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION:

• Primary Carrier _____ Member/Policy# _____ Group# _____

Policy Holder's First Name _____ Last Name _____ MI _____

Policy Holder's DOB _____ SS# _____

Patient's Relationship to Insured (circle one) Self / Spouse / Child / Other _____

• Secondary Carrier _____ Member/Policy# _____ Group# _____

Policy Holder's First Name _____ Last Name _____ MI _____

Policy Holder's DOB _____ SS# _____

Patient's Relationship to Insured (circle one) Self / Spouse / Child / Other _____

PATIENT HISTORY QUESTIONNAIRE

Reason for your visit today: _____

Medical History NONE Diabetes Hypertension Cholesterol Acid Reflux
Asthma COPD Arthritis Heart Attack Stroke Thyroid Gout Anxiety
Depression Atrial Fibrillation Kidney Disease / Dialysis Prostate Sleep Apnea
Sinusitis Cancer: _____ Other: _____

Surgical History NONE Appendectomy Hysterectomy Heart Bypass
Heart Stent Pacemaker Gallbladder Gastric Bypass Bladder Back Hip
Shoulder Knee Cancer: _____
Other: _____

Social History Never Smoked Current Smoker Former Smoker

Family History NONE Retinal Detachment Macular Degeneration Glaucoma

Active Eye Diseases NONE Cataracts Dry Eyes Glaucoma / Suspect

Eye Surgery History NONE

Cataract Surgery - Right Eye / Left Eye / Both

Refractive Surgery (LASIK, PRK, RK) - Right Eye / Left Eye / Both

Cornea Surgery (PKP, DSEK, DMEK) - Right Eye / Left Eye / Both

Glaucoma Surgery (Trab, Tube, Xen, iStent, Other) - Right Eye / Left Eye / Both

Strabismus (Muscle) Surgery - Right Eye / Left Eye / Both

Retina Surgery - Right Eye / Left Eye / Both (Details: _____)

Drug Allergies NONE Penicillin Sulfa Others: _____

Current Medications NONE

FINANCIAL / INSURANCE / REFUND POLICY

We have contracted with insurance carriers or managed care networks to be providers on their plans. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are available to help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of valid insurance, you will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan. Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurance companies select certain services they will not cover or set limitations. Any services identified as such will be your responsibility and payment will be due upon service.
- We must emphasize that filing of claims is a courtesy we extend to our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us for assistance in the management of your account.
- If you do not cancel or reschedule your appointment with at least 24 hours notice, you will be charged a \$50 “no-show” fee.
- Refunds are processed within 30 days of notification from the insurance provider, patient, or explanation of benefits that a refund is due to the patient. The refund is provided in the form of a paper check and is mailed to the patient’s last known address.
- Should you fail to honor your payments for services rendered, your balance will be transferred to a third-party collection service. The undersigned agrees to pay all costs of collections, including but not limited to reasonable legal and third-party fees.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW: I hereby authorize Dallas Retina Center, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Dallas Retina Center will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company. I also understand the Dallas Retina Center patient refund policy, no-show/late cancellation policy and collections policy.

X

Patient Signature

Date

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the **NOTICE OF PRIVACY PRACTICES** of Dallas Retina Center. I also consent to the use or disclosure of my protected health information for the following purposes:

TREATMENT

It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office, as well as other providers.

PAYMENT

Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for the billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

HEALTHCARE OPERATIONS

Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws. I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

DISCLOSURE OF MEDICAL INFORMATION

Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (ex. Spouse)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____

Patient Signature

_____ **Date**