ASSOCIATED RETINAL CONSULTANTS, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

TODAY'S DATE: _____

Name: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ ◯ Home ◯ Cell ◯ Work

Alternate Phone: _____ ◯ Home ◯ Cell ◯ Work

Alternate Phone: _____ ◯ Home ◯ Cell ◯ Work

Social Security Number: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____

Marital Status:

◯ Married ◯ Single

◯ Divorced ◯ Widowed

Ethnicity:

◯ Not Hispanic or Latino

◯ Hispanic or Latino

◯ Unknown

Race:

◯ White ◯ Black or African American

◯ Asian ◯ American Indian or Alaskan Native

◯ Native Hawaiian or Other Pacific Islander

◯ Other

PATIENT'S EMPLOYMENT INFORMATION

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

◯ Employed ◯ Retired

◯ Student/Child ◯ Unemployed

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID No.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID No.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

• ***PLEASE BRING INSURANCE CARDS AND DRIVER'S LICENSE TO FRONT DESK*** •

PATIENT'S PHYSICIAN INFORMATION

Referring Physician: _____

Address: _____

Phone: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Financial Policy Statement

Welcome to Associated Retinal Consultants, P.C., we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. **All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. A return check fee of $25 will be assessed if your check is returned by your bank.

Patient/Guardian Signature: _____ **Date:** _____

Revised: 8.2015

ASSOCIATED RETINAL CONSULTANTS, P.C.

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physicians of Associated Retinal Consultants and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient _____ Date _____
(or person authorized to sign for patient)

Witness _____ Date _____

ASSOCIATED RETINAL CONSULTANTS, P.C.

PATIENT MEDICAL HISTORY

Patient Name: _____ Sex: _____ Date of Birth: _____ Date: _____

Referring Eye Doctor: _____ Address: _____

Medical Doctor: _____ Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Present Illness Please describe your current eye problem: _____

_____

OCULAR HISTORY

Have you ever had any of the following?

Cataract Surgery: ☐ Right Eye ☐ Left Eye Surgeon & Date: _____

Macular Degeneration: ☐ Right Eye ☐ Left Eye

Glaucoma: ☐ Right Eye ☐ Left Eye

Retinal Detachment: ☐ Right Eye ☐ Left Eye

Eye Injury: ☐ Right Eye ☐ Left Eye If yes, please explain: _____

_____

Other Eye Conditions: _____

MEDICAL HISTORY *(Please check all that apply)*

Pregnant ◯ *Yes* ◯ *No*

Pneumonia Vaccine ◯ *Yes* ◯ *No*

Flu Vaccine ◯ *Yes* ◯ *No* For current or upcoming flu season

High Blood Pressure ◯ *Yes* ◯ *No* Controlled with Medication: ◯ Yes ◯ No

High Cholesterol ◯ *Yes* ◯ *No*

Heart Problems ◯ *Yes* ◯ *No* ☐ Heart Attack ☐ Angina ☐ Rhythm Problems
☐ Congestive Heart Failure ☐ Other _____

Neurology ◯ *Yes* ◯ *No* ☐ Stroke ☐ Seizures ☐ Migraine ☐ Parkinson's
☐ Neuropathy ☐ Bells Palsy ☐ Mini Stroke (TIA) ☐ Dementia

Endocrine ◯ *Yes* ◯ *No* ☐ Diabetes Type I Type II How Long? _____
Last Blood Sugar _____ Last A1C _____
☐ Thyroid Disease

Pulmonary ◯ *Yes* ◯ *No* ☐ Asthma ☐ Emphysema ☐ COPD ☐ Tuberculosis
☐ Pulmonary Embolism

Genitourinary ◯ *Yes* ◯ *No* ☐ Enlarged Prostate ☐ Kidney Disease ☐ Kidney Stones

Gastroenterology ◯ *Yes* ◯ *No* ☐ GERD-Reflux ☐ IBS ☐ Ulcers ☐ Hiatal Hernia ☐ Diverticulitis ☐ Crohn's Disease

Hematology ◯ *Yes* ◯ *No* ☐ Anemia ☐ Hepatitis ☐ Lyme Disease ☐ Sickle Cell Disease ☐ HIV ☐ Cancer: If so, what type: _____

Rheumatology ◯ *Yes* ◯ *No* ☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome ☐ Lupus ☐ Auto Immune Disorder

Psychiatry ◯ *Yes* ◯ *No* ☐ Depression ☐ Anxiety ☐ Other: _____

Other medical problems not listed above: _____

_____

_____

Surgical History ◯ *Yes* ◯ *No* ☐ Gallbladder ☐ Appendectomy ☐ Hysterectomy ☐ Bypass – CABG ☐ Heart Stent ☐ Hernia - Herniorrhaphy ☐ Tonsillectomy ☐ Pacemaker ☐ Other: _____

ALLERGIES

Medication ◯ *Yes* ◯ *No*

Please list medication allergies and symptoms: _____

_____

_____

Food ◯ *Yes* ◯ *No* _____

FAMILY HISTORY

Is there an eye disease/problem which runs in your family? ◯ Yes ◯ No

Please list the family relationship for any eye disease/problem you select

☐ Macular Degeneration Relationship: _____

☐ Retinal Detachment Relationship: _____

☐ Glaucoma Relationship: _____

☐ Cataracts Relationship: _____

Is there any significant medical disease which runs in your family? ◯ Yes ◯ No

Please list the family relationship for any medical disease you select

☐ High Blood Pressure Relationship: _____

☐ Heart Disease Relationship: _____

☐ Lung Disease Relationship: _____

☐ Kidney Disease Relationship: _____

☐ Cancer Relationship: _____

☐ Diabetes Relationship: _____

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widow ◯ Unknown

Do You Smoke: ◯ Every Day ◯ Some Days ◯ Former Smoker ◯ Never Smoked

Do You Drink Alcohol: ◯ None ◯ Occasional/Social ◯ 1-2 Drinks Per Day ◯ 3-4 Drinks Per Day

Do You Have a History of Substance Abuse: ◯ Yes ◯ No

If yes, please explain:_____

_____

Occupation: _____ ☐ Retired ☐ Disabled ☐ Unemployed

Living Conditions: ◯ Lives Alone ◯ Assisted Living ◯ Skilled Nursing
◯ Lives with Family or Caregiver

Have You Fallen Within the Last Year: ◯ Yes ◯ No

REVIEW OF SYMPTOMS

Please check the box if you currently have any of the following symptoms

Cardiovascular ☐ Chest Pain ☐ Shortness of Breath ☐ Swelling of Feet

Constitutional ☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Loss of Appetite

Endocrine ☐ Excess Thirst ☐ Excessive Urination ☐ Heat Intolerance
☐ Cold Intolerance

Gastrointestinal ☐ Abdominal Pain ☐ Nausea ☐ Diarrhea

Genitourinary ☐ Pain/Burning on Urination ☐ Blood in Urine

Hematology ☐ Easy Bruising ☐ Prolonged Bleeding ☐ Past Blood Transfusion

HENT ☐ Hearing Loss ☐ Sore Throat ☐ Runny Nose

Integumentary ☐ Rash ☐ Change in Mole

Musculoskeletal ☐ Muscle Aches ☐ Joint Pain ☐ Difficulty Laying Flat

Neurologic ☐ Weakness ☐ Headaches ☐ Scalp Tenderness ☐ Dizziness
☐ Paralysis of Extremities ☐ Tremor

Respiratory ☐ Wheezing ☐ Cough ☐ Coughing Blood

MEDICATIONS: – *Please provide list if additional space is needed.*

Name of Medication	Strength	Frequency

OCULAR MEDICATIONS:

Name of Medication	Strength	Frequency

Associated Retinal Consultants Financial Policy

Thank you for choosing Associated Retinal Consultants as your healthcare provider. We are committed to providing you with high quality care. Our Medical and Business Office staff members will work very hard to make sure you have a positive experience with us. Due to the changes as a result of the Affordable Health Care Act, Associated Retinal Consultants has determined it necessary to implement the following financial policy. Please make sure to read the following in its entirety and sign that you have read and understand this policy.

WE ACCEPT MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, CHECKS AND CASH.

Insurance & Insurance Collection
Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, we have experience with insurers stalling, denying, and reducing payments. Please bring all of your insurance cards to each and every appointment and notify the staff if there have been any changes to your policy.

Medicare and Medicare Advantage Plans
As a participating provider, we will bill your Medicare carrier. **If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card.** You are responsible for your annual deductible and 20% co-insurance and we must collect it. We will be happy to bill your secondary payer as well. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

Medicare Patients Residing in a Rehab or Skilled Nursing Facility
Patients temporarily or permanently residing in a rehab or skilled nursing facility often have restrictions on services approved for payment in physician offices. It is critical that you let our office staff know this information and have the facility information available even if the reason for the stay is unrelated to your eye condition. Prior authorization needs to be obtained for any services provided to you in our office while you are staying in one of these facilities. Lack of prior notification could result in the patient being responsible for the balance.

HMO PLANS
All co-pays must be paid at each and every visit. There can be no exceptions due to contracting and uniform compliance rules. **You are responsible for getting proper referral information and authorizations in advance of your appointment. It is the patient's responsibility to verify with your insurance company that our physician is enrolled in your insurance plan.** You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

PPO PLANS
We have agreed to accept the discounted rate from your plan, however all co-insurance and deductibles are your responsibility and **due at the time of each and every visit**.

Co-payments, Co-insurance and Patient Deductibles
All co-payments, deductibles, share of costs and coinsurances are **due at the time of service**. Your insurance company deducts this from our payment automatically. Associated Retinal Consultants, reserves the right to charge a finance fee of 1% of your patient balance if not paid within 60 days past the date of the statement unless a payment arrangement has already been made with the billing office.

Financial Assistance for Injectable Medications
Due to the high cost of some ophthalmic injectable medications, we ask that you investigate your insurance to better understand your benefits and also investigate insurance coverage when you have the option to switch plans. We also ask that you follow through with these available Patient Assistance Programs to minimize your potential cost for these expensive medications. We will do our best to assist you with any part of this process and are committed to helping you determine your eligibility for these programs**.** Physician office staff can facilitate getting you the appropriate forms to complete for these assistance programs and it is your responsibility to follow up to ensure timely submission. **Ultimately, you are responsible for any costs not covered by your insurance or drug assistance programs.**

No Insurance or Services not Covered by your Insurance
Patients without any health insurance or patients who have coverage but the services are not covered by your insurance are expected to pay **in full prior to or at the time-of-service**. This includes all office visits, tests, injections and surgical procedures.

Unpaid Balance Fees
Associated Retinal Consultants reserves the right to charge a fee of 1% for each statement sent to you for any patient-responsibility balance past due. This fee will not be assessed for the first statement sent.

About your information
We require you to bring your insurance card(s) with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you.

We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

Form Completion and Record Copying
Additional fees may be charged for form completion, including disability forms, etc. Fees vary depending on the complexity of the forms. Fees for copies of medical records will be in accordance with the State of Michigan Medical Records Access Act.

Returned Check Fee
There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

_____ Date: _____
Signature of Patient or Responsible Party

_____
Printed Name of Patient