RETINA CONSULTANTS of Orlando

NEW PATIENT REGISTRATION FORM

Today's Date: _____

First Name: _____ Middle Initial:_____ Last Name:_____

Email*: _____

Birthday: _____/_____/_____ Social Security No.: _____ - _____ - _____

Home Phone: _____ Mobile Phone: _____

Patient Gender: ❑ Male ❑ Female ❑Other: _____

Marital Status: ❑Married ❑ Single ❑ Divorced ❑ Widow(ed)

Permanent Street Address: _____

City: _____ State: _____ Zip: _____

Local Address (if other than permanent): _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

First Name: _____ Middle Initial:_____ Last Name:_____

Relationship: _____ Emergency Contact Phone: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number: _____

Address: _____

PRIMARY CARE PHYSICIAN ❑ I Don't have a PCP

Doctor: _____Phone: _____

REFERRED BY

❑ Doctor: _____ ❑Relative/Friend:_____

❑Insurance Network ❑ Internet/Google ❑ Social Media/Facebook/Instagram ❑ Other:_____

PAYMENT INFORMATION: Payment for self-pay visits, co-pays and deductible is expected when services are rendered unless other arrangements are made in advance. How will you be paying for today's services?

❑ Cash ❑ Check ❑ MC ❑ Visa ❑ AMEX ❑ DSC ❑ Apple Pay ❑ Google Pay ❑ Care Credit

INSURANCE AUTHORIZATION: 1. I hereby authorize the physicians of Retina Consultants of Orlando to furnish information to insurance carriers concerning my illness, accident and/or treatments and I hereby irrevocably assign to the above physicians all payments for medical services rendered to myself or to my dependents. 2. I understand that I am financially responsible for all charges whether or not covered by insurance. 3. I also hereby authorize you to obtain copies of my medical records from other physicians if necessary. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature X_____ **Date:**_____

RETINA CONSULTANTS of Orlando

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

Home Phone ☐ Yes ☐ No Cell Phone ☐ Yes ☐ No

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Retina Consultants of Orlando to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Retina Consultants of Orlando's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____

RETINA CONSULTANTS
of Orlando

NOTICE OF PRIVACY PRACTICES
Effective April 1, 2003

You have our promise and commitment to protect your medical information. We understand that medical information about you and your health is very personal. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice of Privacy Practices, which describes:

How medical information about you may be used and disclosed and how you can get access to this information.

We are required by law to have your written authorization before we use or disclose your health information for purposes other than providing or coordinating your health care, payment or reimbursement for the care we provide to you, and related administration. activities that support your treatment.

Certain laws may require or allow us to use and disclose your health information for other purposes without your authorization.

You also have important rights, including:

- The right to inspect and copy the protected health information (PHI) we maintain about you
- The right to request restrictions of your protected health information (PHI)
- The right to request to receive confidential communications from us by alternative means or at an alternative location
- The right to request an amendment of protected health information (PHI)
- The right to receive an accounting of certain disclosures we have made of your protected health information (PHI)
- The right to file a complaint if you feel your rights have been violated

We have available a detailed Notice of Privacy Practices that explains in detail your rights and our obligations under the law. Please note that we may revise our Notice from time to time and a copy is available by calling our office.

You have the right to receive a copy of our most current Notice in effect or, if you have any questions, concerns, or complaints about the Notice, please contact our Privacy Officer, Dr. Jose Echegaray 407-637-2096. You will not be penalized for filing a complaint.

NOTICE OF ACKNOWLEDGMENT OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability Act of 1996 (HIPAA) I have certain privacy rights with respect to my protected health information. I understand that the information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be directly and indirectly involved in that treatment
- Get paid from third-party payers
- Perform normal healthcare operations, such as quality assessments and medical certifications.

I have received a summary of Retina Consultants of Orlando's Notice of Privacy Practices, but I know that I may contact its Privacy Officer for a detailed Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my medical information. . I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restriction, but if you do agree, you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

RETINA CONSULTANTS
of Orlando

FINANCIAL PRACTICES DISCLOSURE

Welcome to Retina Consultants of Orlando. Our practice participates in many medical insurance plans. If we are participating providers for you 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: During the transitional period associated with starting a new practice, we will make every effort to work with your insurance company to obtain authorization for your care with the same in-network benefits that you currently have. In most cases, this is not a problem and your insurance carrier will allow us to treat you just as if we were an in-network provider. If there is an instance where this is not possible, we will make whatever adjustments necessary so that you are not charged anything more than if you had seen an in-network provider. Please know that we are making every effort to become participating with the primary payers in our region. Unfortunately, the process can sometimes be lengthy. We will keep you informed!

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.

X _____ _____

Patient Signature **Date Signed**

Relationship to patient (If signed by a personal representative of patient)**:** _____

Patient Name: _____ **DOB:** _____

RETINA CONSULTANTS of Orlando

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

Retina Consultants of Orlando
Name of Person/Organization Receiving Information

616 E Altamonte Dr Ste 101, Altamonte Springs, FL 32701
Address City / State / Zip

(407) 637-2096//(407) 637-2097
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

****

Date Sent: _____ **By:** _____ **Via:** _____