KOCH EYE ASSOCIATES

WELCOME!

Patient Registration Information

Date: _____ Acct#: _____

Patient Name: _____ Sex: M F Age: _____
(First) (M) (Last)

Birthdate: _____ Patient SS#: _____

Home Address: _____
(Street) (Apt. #)

_____
(City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave a message if unable to reach you? (may contain personal information): ___YES ___NO

Email Address: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____

How did you hear about us? _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Insurance Information

	Primary Insurance	Secondary Insurance
Ins. Co. Name:		
Ins. Co. Address:		
Ins. Co. Phone:		
Group #:		
ID #:		
Name of Policyholder:		
Policyholder's DOB:		
Policyholder's SS#:		
Relationship to Patient:		
Employer:		

*****OVER PLEASE*****

KOCH EYE ASSOCIATES

Health History Questionnaire

Please complete this form to the best of your knowledge.

Current Medications

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Prescription Drugs/ Non Prescription Drugs

Allergies to Medications
(hives, itching, rash):

_____
_____
_____
_____

Do you wear prescription eye glasses or contact lenses? **YES** **NO**
Please bring your corrective eyewear with you to your appointment.

Health History

Please include eye and general health history.
Eye Diseases (glaucoma, macular degeneration, diabetic retinopathy, retinal tear/detachment, uveitis, iritis, trauma, and/or surgeries i.e. laser, lasik, cataract, cryo, scleral buckle):

Previous

_____

_____

Current

_____

_____

General Health and Surgeries (heart disease, high blood pressure, diabetes, thyroid, arthritis, cancer, etc.):

_____

_____

_____

Social History: _____Alcohol _____Drugs _____Smoking _____Exercise

Do you have a history of blood transfusions? **YES** **NO**

Have you ever been tested for HIV and/or Hepatitis? **YES** **NO**

If yes, was your test positive or negative? _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (SPOUSE, PARENT OR LEGAL GUARDIAN)
(If other than patient)

Name: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Driver's License: _____

Billing Address: _____
(Street) (Apt)

_____
(City) (State) (Zip)

Home Phone: _____ Work #: _____Cell #: _____

ASSIGNMENT OF BENEFITS

I request payment of authorized Medicare and/or Insurance carrier benefits be made on my behalf to Retina Consultants for any service furnished to me by Retina Consultants' physicians. I authorize my physician to release to Medicare and/or my Insurance carrier(s) any information needed to determine these benefits or the benefits payable for related services. **I agree to provide all referrals as required by my insurance carrier(s)**. I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days as a result of incorrect insurance information provided by me (not errors on part of provider claim submission) will become my financial responsibility. I understand any unpaid balances and non-covered services are my financial responsibility. Retina Consultants reserves the right to charge a $25.00 service fee for any unpaid balances including co-pays and deductibles that are due at the time of service. I understand I will be charged a missed appointment fee of $50.00 per visit should I fail to provide 24 hours notice of cancellations or rescheduling. I also understand I will be charged a $35.00 fee for any returned check.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: _____ *Date*: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Authorize third party to verify insurance benefits and eligibility.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health 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 at the address above 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature: _____ *Date*: _____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____