RCT RETINA CENTER OF TEXAS™

PATIENT INFORMATION

Please fill in the information and email the completed form to patient.documents@retinacentertx.com or fax it to (817) 865-6790.

Legal First Name ______________________________ MI _____ Legal Last Name ________________________________

Address ____

City ____ State ________ Zip _________________

Home Phone ______________________ Cell Phone ______________________ Other Phone ____________________

Email Address ____

Date of Birth ____________________ Sex ______ Race ____________________ SS# __________________________

Primary Language ____ Ethnicity: Hispanic Non-Hispanic

Marital Status (*Circle*) ☐ S ☐ M ☐ W ☐ D Spouse Name ____

EMPLOYER __________________________________ Address ____

City _________________________________ State _____ Zip __________ Work Phone __________________________

Occupation ____

Emergency Contact ____

Relationship to patient ____ Phone ____________________

Please tell us if a Physician referred you

Referred by ____ ☐ OD ☐ MD ☐ DO Phone ______________________

Address ____ City ____________________ State _____ Zip __________

Family Physician ____ Phone ____________________

Address ____ City ____________________ State _____ Zip __________

*****If your insurance requires a referral from your primary care physician, please ensure we have received it.**

If Patient is a Minor or Dependent

Name of Responsible Party ____ Phone ____________________

Address ____ City ____________________ State _____ Zip __________

Relationship to Patient ____

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Retina Center of Texas to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to Retina Center of Texas. I understand that I am financially responsible for ALL charges for services rendered to me by Retina Center of Texas.

____ _________________________

Patient's Signature (or Authorized Representative/Guardian) Date

INSURANCE INFORMATION

Please fill in the information and email the completed form to patient.documents@retinacentertx.com or fax it to (817) 865-6790.

There is no guarantee that your insurance company will pay for all services rendered. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. If we have not received payment within sixty days, we will notify you and unpaid balances will become your responsibility, and we will expect payment in full at that time. It is the patient's responsibility to pay any deductible, or any portion of the charges as specified by the plan at the time of visit.
We are happy to help with insurance questions relating to how a claim was filed, however, specific coverage issues, can only be addressed by the insurance company's member services department (number is on the insurance card).
Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about financial arrangements may be directed to the physician's office at any time. Please do not hesitate to contact us. We are here to help you!
PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO ENSURE THAT ANY REQUIRED REFERRALS FOR TREATMENT ARE OBTAINED BEFORE THE VISIT OR THE PATIENT MAY BE FINANCIALLY RESPONSIBLE DUE TO LACK OF THE REFERRAL AT TIME OF SERVICE.

Primary Insurance Company ______________________________

Phone ____________ Group # ____________ Subscriber ID# ____________

Office Visit Copay __________ Specialist Visit Copay __________ Deductible? ☐ Yes | ☐ No

If different from patient: Subscriber Name ______________________________

Date of Birth __________ SS# ____________ Relationship ____________

Secondary Insurance Company ______________________________

Phone ____________ Group # ____________ Subscriber ID# ____________

Office Visit Copay __________ Specialist Visit Copay __________ Deductible? ☐ Yes | ☐ No

If different from patient: Subscriber Name ______________________________

Date of Birth __________ SS# ____________ Relationship ____________

Assignment of Benefits / Authorization to release information:

I hereby authorize Retina Center of Texas to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors and hospitals.

I hereby authorize Retina Center of Texas, the group hospital benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Retina Center of Texas for charges not covered by this authorization.

I permit a copy of this authorization to be used in place of the original.

______________________________ ______________

Patient's Signature (*or Authorized Representative/Guardian*) Date

PATIENT HISTORY QUESTIONNAIRE

Please fill in the information and email the completed form to patient.documents@retinacentertx.com or fax it to (817) 865-6790.

CURRENT EYE MEDICATIONS: (List medication name / dose. If additional space is needed please provide a separate list.)

CURRENT OTHER MEDICATIONS: (List medication name / dose. If additional space is needed please provide a separate list.)

ALLERGIES:

EYE CONDITIONS / PREVIOUS EYE SURGERIES: Please check ☑ the following.

☐ Retinal Detachment	☐ Corneal Disease	☐ Other:
☐ Macular Degeneration	☐ Iritis/Uveitis	
☐ Cataracts	☐ Glaucoma	

MEDICAL CONDITIONS / PREVIOUS SURGERIES: Please check ☑ the following.

☐ High Blood Pressure	☐ Asthma	Thyroid Disease	☐ Other:
☐ Diabetes	☐ Migraines	Sinus Problems:	
☐ High Cholesterol	☐ Heart Disease	☐ Arthritis	

FAMILY HISTORY: Please check ☑ the following.

☐ Retinal Detachment	☐ Macular Degeneration	☐ Other:

Social History: Check your answer

Do you drink alcohol?	☐ No	☐ Yes	(*If yes, how often?*)	
Do you smoke?	☐ No	☐ Yes	(*If yes, how often?*)	
Do you use street drugs?	☐ No	☐ Yes	(*If yes, please explain*)	

PREFERRED PHARMACY ________________________________ Phone ____________________________

Address ____

Height: ________________________ **Weight:** ________________________________

Name:		**Date:**	

MRN: __________________

PATIENT HISTORY QUESTIONNAIRE

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REVIEW OF SYSTEMS:	If you are currently having any problems in the following areas, please check Yes and explain in the open box under the common symptoms. Check none if not experiencing.	
CONSTITUTIONAL: ☐ Yes	Fatigue, fever, night sweats, weakness, weight gain, weight loss, other:	☐ None
CARDIOVASCULAR: ☐ Yes	Arrhythmia, calf pain, chest pressure or discomfort, irregular heartbeat/palpitations, leg swelling, tachycardia, other:	☐ None
METABOLIC/ENDOCRINE: ☐ Yes	Cold intolerance, heat intolerance, excessive thirst, excessive eating, excessive urination, other:	☐ None
INTEGUMENTARY: ☐ Yes	Abnormal hair distribution, dry skin, hives, itching, nail changes, rash, skin changes, skin lesion, skin nodules, skin sores, ulcer, other:	☐ None
HEENT: ☐ Yes	Exophthalmos, hearing loss, hoarseness, lump in neck, nasal congestion, sinus problems, sore throat, tinnitus, vertigo, other:	☐ None
GASTROINTESTINAL: ☐ Yes	Abdominal pain, black tarry stools, constipation, decreased appetite, diarrhea, dysphagia, food intolerance, heartburn, increased appetite, jaundice, nausea, vomiting, other:	☐ None
NEUROLOGICAL: ☐ Yes	Balance disturbances, dizziness, focal weakness, headache, memory difficulty, numbness of extremities, other:	☐ None
MUSCULOSKELETAL: ☐ Yes	Joint pain, back pain, fracture, gait disturbance, joint stiffness, joint swelling, muscle cramping, muscle weakness, other:	☐ None
RESPIRATORY: ☐ Yes	Asthma, cough, shortness of breath(dyspnea), hemoptysis, wheezing, other:	☐ None
GENITOURINARY: ☐ Yes	Painful urination, genital lesions, blood in urine, irregular menses, other:	☐ None
PSYCHIATRIC: ☐ Yes	Depressed mood, emotional changes, euphoria, frequent nightmares, hallucinations, insomnia, irritability, nervousness, stress, other:	☐ None
HEMATOLOGIC/LYMPHATIC: ☐ Yes	Bleeding, bruising, diseases of the lymph nodes, other:	☐ None
IMMUNOLOGIC: ☐ Yes	Environmental allergies, food allergies, seasonal allergies, other:	☐ None

Name:		**Date:**	

MRN: ___________________

HIPAA PRIVACY
DISCLOSURE & CONSENT

TO THE USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Retina Center of Texas (hereinafter referred to as "RCT") will maintain a record of the care and services you receive at RCT. This consent only covers your protected health information created while you are a patient of RCT. Your protected health information pertains to your diagnosis and/or treatment at RCT, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to RCT's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how RCT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of RCT's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.

______________________________ ______________________________
Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

______________________________ ______________________________
Witness's Signature Date

<u>HIPAA Authorization</u>: I authorize the following person(s) to discuss my medical care and billing/insurance information with the Retina Center of Texas staff on my behalf:

Name ______________________________ Relationship ____________________

Name ______________________________ Relationship ____________________

SKILLED NURSING FACILITY (MEDICARE PATIENT ONLY)

ARE YOU CURRENTLY UNDER CARE BY A SKILLED NURSING FACILITY?

YES OR NO

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patient's needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $15.00 service charge on all returned checks. After receiving a returned check, Retina Center of Texas will only accept cash, money order, or credit card.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.

3. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignments for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court-ordered judgment must be between the individuals involved, without including our facility.

8. **In the unlikely event, your payment is returned to us unpaid**, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (817) 865-6800.

____ __________________________

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____ __________________________

Witness's Signature Date

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