GREATER DALLAS RETINA

Patient Information

PLEASE PRINT AND PROVIDE COMPLETE INFORMATION

First Name _____ MI _____ Last Name _____

Date of Birth _____ Sex ☐ Male ☐ Female SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race ☐ White ☐ Black/African American ☐ American Indian
☐ Asian ☐ Native Hawaiin/Other Pacific Islander ☐ Decline

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Occupation _____ Employer _____

Emergency contact _____

Relationship to patient _____ Phone _____

Referral doctor _____ ☐ OD ☐ MD/DO Family doctor _____

Phone _____ Phone _____

If patient is on Medicare, are you under care by a Skilled Nursing Facility (SNF)? ☐ Yes ☐ No

If patient is minor or dependent, Name of Responsible Party _____

Relationship to patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Please provide signed Power of Attorney document, if applicable

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____ City _____ State _____ Zip _____

PLEASE READ AND SIGN BELOW

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

Patient Signature _____ _____

GREATER DALLAS RETINA

Insurance Information

PLEASE PRINT AND PROVIDE COMPLETE INFORMATION

Date

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. The phone number for the insurance company's member services department can usually be found on your insurance card.

Our practice firmly believes that a good doctor/patient relationship is based upon undertanding 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!

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.

Medicare # _____ Medicaid # _____

Primary Insurance Company _____

Insured Name _____ Insured Date of Birth _____

Insured ID #_____ Group # _____ Relationship to Patient _____

Secondary Insurance Company _____

Insured Name _____ Insured Date of Birth _____

Insured ID #_____ Group # _____ Relationship to Patient _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Greater Dallas Retina to release any information concerning my care for the purpose of claims to federal, state, city, or town government agencies, third party payers of all categories, doctors, and hospitals.

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

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

Patient Name _____ Date of Birth _____

_____ _____

GREATER DALLAS RETINA

Patient Financial Responsibility

Patient Signature Date

PLEASE READ AND SIGN BELOW

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 patients' 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, check, and credit card. There is a $25.00 service charge on all returned checks. After receiving a returned check, Greater Dallas Retina will only accept cash, money order, or credit card.
2. **It is the your responsibility** to be aware of the contract benefits of your insurance carrier or any copayment 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. **As a courtesy, 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 with 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. Please remember that although we accept assignment for Medicare, the patient is responsible, by law, 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 that your payment is returned to us unpaid, we will resubmit 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 permitted by state law.
9. Under the program created by the Affordable Care Act (ACA), the federal government has mandated a 90-day grace period for all participants. What this means is that your doctors are notified when a patient is in their second or third month grace period and insurance premiums have not been paid current. How this impacts your medical claim is important as your insurance may or may not pay your claims. This signed notification represents your financial obligation that should your premiums fall behind, the charges during your grace period and any past due amounts will become your financial responsibility.

If you have any questions about the above financial responsibilities, please speak with our billing staff.

Patient Name _____ Date of Birth _____

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

By signing this form, you acknowledge that you have received a copy of our *Notice of Privacy Practices* and have had an opportunity to read it, I also understand that I may speak with the Privacy Officer if I have any questions.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

AUTHORIZATION TO DISCLOSURE HEALTH INFORMATION

I authorize the following persons to discuss my medical care and billing/insurance information with the Greater Dallas Retina staff on my behalf:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

GREATER DALLAS RETINA

Patient Health Questionnaire

Patient Name _____ Date _____

CURRENT EYE MEDICATIONS

☐ None
☐ I have a medication list

CURRENT OTHER MEDICATIONS

☐ None
☐ I have a medication list

ALLERGIES AND DRUG REACTIONS

☐ No known drug allergies

EYE CONDITIONS AND PREVIOUS SURGERIES

☐ None
☐ Retinal Detachment
☐ Macular Degeneration
☐ Diabetic Retinopathy
☐ Retinal Vein Occlusion
☐ Iritis or Uveitis
☐ Cataracts
☐ Corneal Disease
☐ Glaucoma
☐ Other:

MEDICAL CONDITIONS AND PREVIOUS SURGERIES

☐ None
☐ High Blood Pressure
☐ Diabetes
☐ Arthritis
☐ Asthma
☐ Migraines
☐ Heart Disease
☐ Thyroid Disease
☐ Sinus Problems
☐ Other:

FAMILY EYE HISTORY

☐ None
☐ Retinal Detachment
☐ Macular Degeneration
☐ Other:

SOCIAL HISTORY

Do you smoke?	☐ Yes ☐ No	*If yes*, how often? _____
Do you drink?	☐ Yes ☐ No	*If yes*, how often? _____
Do you use street drugs?	☐ Yes ☐ No	*If yes*, how often? _____
Have you had any recent falls	☐ Yes ☐ No	*If yes*, how many? _____

GREATER DALLAS RETINA

Patient Health Questionnaire

Patient Name _____ Date _____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, please circle and explain.

Allergy/Immunology ☐ None	Environmental allergies, food allergies, other:
Blood/Lymph Nodes ☐ None	Bruising, easy bleeding, swelling, other:
Cardiovascular ☐ None	Chest pressure, discomfort, irregular heartbeat, other:
Constitutional ☐ None	Fatigue, fever, night sweats, weight loss, other:
Endocrine ☐ None	Cold intolerance, heat intolerance, other:
Ear, Nose, Throat ☐ None	Hearing loss, sinus problems, hoarseness, other:
Gastrointestinal ☐ None	Constipation, diarrhea, vomiting, other:
Genitourinary ☐ None	Frequent urination, incontinence, back pain, other:
Skin ☐ None	Rash, skin lesion, infection, other:
Musculoskeltal ☐ None	Joint swelling, muscle weakness, stiffness, other:
Neurological ☐ None	Dizziness, tremors, headache, other:
Psychiatric ☐ None	Mood swings, anxiety, depression, other:
Respiratory ☐ None	Cough, wheezing, snoring, other: