Tulsa Retina Consultants

Patient Registration (PLEASE PRINT CLEARLY!)

Patient's Name:_____Date of Birth: _____
Last Name MI First Name

SS#:_____ ☐Male ☐ Female ☐Single ☐Married ☐Widowed ☐ Divorced ☐ Separated

Street Address: _____

City/State/Zip Code: _____

Ethnicity: (check one) ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Race: (check one) ☐ White ☐Black or African American ☐American Indian or Alaskan Native ☐Asian ☐Other Race
☐Native Hawaiian or other Pacific Islander ☐Unknown ☐Multiracial ☐Hispanic ☐Not reported

Language: ☐**English** ☐**Arabic** ☐**Chinese** ☐**French** ☐**German** ☐**Spanish** ☐**Italian** ☐**Japanese** ☐**Russian** ☐ **Korean** ☐**Other**_____

Home Phone w/Area Code _____ **Cell Phone w/Area Code**: _____

Email Address_____

Spouse's Name:_____ **SS #:**_____

Spouse's Employer:_____ **Spouse's Work Phone #:**_____

Patient's Employer:_____ **Work Phone w/Area Code:**_____

Responsible Party:_____ **Relationship:** ☐Self ☐Spouse ☐Parent ☐Other:_____

If patient is a Minor, are parents ☐Married ☐Divorced Custodial Parent:_____

Custodial Parent's Home Phone w/Area Code:_____ **Work Phone w/Area Code:**_____

Custodial Parent's SS #:_____ Date **of Birth:** _____

In case of emergency, contact (not living with you):_____

Phone Number w/Area Code:_____ **Relationship to Patient:**_____

Is this work-related? ☐ Yes ☐ No If **yes, date of injury?**_____**Claim #:**_____

How did this injury happen?_____

Referring Doctor's Name & Phone Number:_____

Primary Care Doctor's Name & Phone Number:_____

FOR NEW PATIENTS ONLY: PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

If you do not have insurance, have you applied for Medicaid? ☐Yes ☐No If yes, what is the name and phone number of the social worker with whom you are working?_____

- **I hereby authorize the payment of medical benefits to Tulsa Retina Consultants for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize Tulsa Retina Consultants to release any medical information necessary to complete and process my insurance claims.**

>>_____ _____
>>***Patient's OR Insured's Signature*** (If patient is a Minor, must have Responsible Party Signature) Date

I authorize physicians of Tulsa Retina Consultants to treat me and use my personal health information for healthcare operations.

>>_____ _____
>>***Patient's Signature*** (OR Parent if patient is a Minor) Date

Tulsa Retina Consultants

Billing Policy

The following sets forth the general billing policy of Tulsa Retina Consultants. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Tulsa Retina Consultants with current, accurate billing information at the time of check in and to notify TRC of any changes in this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that there is a $20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $20 fee (payable prior to completion) is required.

- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of Tulsa Retina Consultants.

_____ _____

Legal Signature Date

_____

Relationship to Patient