Tulsa Retina Consultants, PLLC

Patient Registration

Please Print Clearly

PLEASE PRESENT INSURANCE CARDS, PHOTO ID AND COMPLETE THE REQUESTED INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

Mailing Address: _____
City State ZIP

Home Phone: _____ Cell Phone: _____ SSN_____

Language: _____ Ethnicity: _____ Race: _____

Sex: Male ( ) Female ( ) Marital Status: Married ( ) Single ( ) Other ( )

Email: _____ Contact Preference: _____

In case of emergency, notify: _____ Phone: _____

Employer Name: _____ Employer Phone #:_____

Primary Ins (1): _____ ID#: _____

Name/Policy Holder: _____ SSN:_____ DOB: _____

Secondary Ins (2): _____ ID#: _____

Name/Policy Holder: _____ SSN:_____ DOB: _____

Guarantor: _____ Relationship: _____
Last First MI

Mailing Address: _____
City State ZIP

Referring Doctor:_____ Primary Care Doctor: _____

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 percentage based collection costs, attorney fees and other collection costs that may be incurred to enforce the collection of any amount outstanding. I hereby authorize Tulsa Retina Consultants to release any medical information necessary to complete my insurance claims. I authorize the physicians of Tulsa Retina Consultants to treat me and use my personal health information for healthcare operations.

_____ _____
Patient Signature (or insured if patient is a minor) Date

Tulsa Retina Consultants

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours of notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$50.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered a **NO SHOW.** Patients who No Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may be subject to a **$50.00** No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and communication. Questions about the policy should be directed to the Billing Department (918) 949-4577.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ **Date of Birth**_____

Patient Name(Please Print)

_____ **Date**_____

Signature of Patient or Patient Representative

Tulsa Retina Consultants, PLLC
Patient Agreement (HIPAA)

AUTHORIZATION FOR MEDICAL TREATMENT

Tulsa Retina Consultants, PLLC and its personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Tulsa Retina Consultants PLLC and are accessible to office personnel. Office personnel may use and disclose medical information for office operations, functions and to any other physician or health care persons involved in my continuum of care. Safeguards are in place to discourage improper access, Tulsa Retina Consultants, PLLC and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker, compensation carrier, or self-insured employer group liable for any part of Tulsa Retina Consultants, PLLC charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that Tulsa Retina Consultants, PLLC advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquire Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY

I understand that Tulsa Retina Consultants, PLLC will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, I guarantee payment for any amount due for such services provided by Tulsa Retina Consultants, PLLC. A return check charge of $35 will be assessed per item, no matter the dollar amount.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further

certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____	_____	_____	_____
Signature of Patient or Patient's Legal Representative	**Relationship**	**Date Signed**	**Patient Name Printed**

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

_____	_____	_____	_____
Name (Please Print)	Relationship	Name (Please Print)	Relationship
_____	_____	_____	_____
Name (Please Print)	Relationship	Name (Please Print)	Relationship

I Authorize Confidential Messages Containing Protected Health Information To Be Left On:

My Home Phone Answering Machine: #_____

My Cell Phone: #_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this Office Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES. A copy is posted in this Office Practice/Clinic. A copy of this can also be requested from the front desk of Tulsa Retina Consultants.

_____	_____	_____
Patient or Patient's Legal Representative	**Date Signed**	**Witness**

Tulsa Retina Consultants, PLLC
Patient Payment Policy

Tulsa Retina Consultants strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

Co-pays

We require payment of co-pays at the time of service, and reserve the right to refuse treatment.

No Insurance

If you do not have insurance, we will collect up to $280 for your initial visit and up to $160 on your follow-up visits. There will be additional charges to your office visit if test, treatment and/or procedures are required. It is our policy to collect payment for testing and procedures at the time of service. If you are unable to pay at that time, you may speak to a representative before your testing or procedure is performed, to discuss possible treatment and/or payment options.

Payments

We accept cash, Visa, MasterCard, Discover, American Express and Care Credit. We also accept payment by debit cards. Tulsa Retina Consultants reserves the right to require payment for services to be made at or before the time of service.

Fees

In the event that your account is placed for collection, a percentage based fee could be added to your account. In the event of an NSF (Non-Sufficient Funds) check, there will be a $35 NSF charge added to the balance due. We may bill $18 for forms or letters that a provider completes on your behalf. For medical records requested for personal use, we charge a copy fee of $5.

Claim Filing

We file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all Federal and State requirements and in cases where we have an agreement or we are participating with a certain insurance, we bill accordance with their contractual requirements. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payments to Tulsa Retina Consultants, PLCC and we will apply it to your account.

Medicaid

We file Medicaid patients' claims for the state of Oklahoma. If you have assistance from another state, you will be responsible for payment of the services you receive and the filing of your own claims. It is the Medicaid patient’s responsibility to obtain a referral and/or authorization.

Authorizations, Indian Health and HMOs

Some insurance companies require an authorization for services rendered by a Specialist. While we will assist in the process, it is ultimately your responsibility to obtain any needed authorizations. Failure to obtain one may result in no payment from the insurance company and you will be responsible for payment.

Pre-authorization for Procedures

Some insurance companies require pre-authorization before you have a procedure. While we will assist in the process, it is ultimately your responsibility to obtain any needed pre-authorizations, and failure to do so may result in your insurance company refusing to pay your claim. Any refusal of payment by insurance for this reason is your responsibility.

Referrals

If you see a doctor that is out-of-network with your insurance carrier, or if you use an insurance company that requires a referral, you are responsible for obtaining it from your primary care clinic or physician. Failure to obtain a referral may result in a lower or no payment at all from the insurance company and you will be responsible for payment.

Surgery

Upon request, the Surgery Counselor will explain a cost estimate, which shows your financial responsibility based on the benefit levels and coverage of your insurance plan. That amount depends on your coverage and your co-pay, co-insurance and deductible amounts. We will collect the amount you are responsible for prior to surgery services being rendered.

Dependents

You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with dependent, it is your responsibility to obtain reimbursement from the other party involved.

Attestation Statement

I have read, understand, and agree to the above Tulsa Retina Consultants Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Tulsa Retina Consultants to extend credit.

I authorize my insurance benefits to be paid directly to Tulsa Retina Consultants.

I authorize Tulsa Retina Consultants to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____

Print Name of Patient

_____ _____

Patient or Patient's Legal Representative **Date Signed**