Tulsa Retina Consultants

Tulsa Retina Consultants, PLLC

Patient Registration Form

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 ❑ Married Status: Married ❑ Single ❑ Divorced ❑ Widowed ❑

Email: _____ Contact Preference: Text ❑ Call ❑ Email ❑

Emergency Contact: _____ Relation: _____ Phone: _____

Referring Doctor: _____ Primary Care Doctor: _____

Employer Name: _____ Employer Phone: _____

Primary Insurance (1): _____ ID# _____

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

Primary Insurance (2): _____ ID# _____

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

Guarantor: _____ Relationship: _____

Mailing Address: _____

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 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 my 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's Signature *(or insured if patient is a minor)* Date

Tulsa Retina Consultants

Financial Patient Agreement

We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits, are your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. Patient Payment: **All co-payments and deductibles are to be paid at the time of service.** This arrangement is part of your contract with your insurance company.

3. Forms: There is a $25 fee for completing FMLA, sick leave, and disability insurance forms. This fee must be paid when the forms are completed.

4. Registration: All patients must complete our patient registration form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim.

5. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not part to the contract.

6. Uninsured patients: We offer a discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. Hardship applications are available to those who qualify, please ask to speak to a billing representative.

7. Collections: If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency.

8. Missed appointments: Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial patient agreement and agree to abide by its guidelines.

_____

Patient Name *(Please Print)*

_____ _____

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

Tulsa Retina Consultants

HIPAA PRIVACY AUTHORIZATION FORM & POWER OF ATTORNEY

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I certify that I have been made aware of the Tulsa Retina Consultant's Notice of Privacy Practices and that I have a right to receive a copy upon request. This Notice describes the types of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Tulsa Retina Consultant's health care operations. The Notice also describes my rights and Tulsa Retina Consultant's duties with respect to my protected health information.

I understand that copies of the Notice of Privacy Practices are available in the registration areas of each facility. Tulsa Retina Consultant's reserves the right to change the privacy practices that were described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed to me, or by asking for one at the time of my next appointment.

Release of Information

I hereby give permission to person(s) listed below to receive information about the care given by Tulsa Retina Consultant's, PLLC.

_____ _____
Name Relationship

_____ _____
Name Relationship

Acknowledgement of Notice of Privacy Practices

A complete description of how your medical information will be used and disclosed by this office is in our Notice of Privacy Practice Manual. A copy is available for your review from our front desk staff.

_____ _____
Patient or Patient's Legal Representative *(or insured if patient is a minor)* Date

Medical Power of Attorney

Does anyone hold P.O.A. for you? Yes ❑ No ❑

If yes, who? _____

Please provide paperwork to front desk.

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Dilation

Dilating drops are used to dilate or enlarge the pupils of the eye, allowing the physician to get a better view of the inside of the eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

The dilating drops may trigger adverse reactions, such as acute angle-closure glaucoma. This is extremely rare and treatable with immediate medical attention.

If the complication happens during surgery, your surgeon may need to perform another surgery immediately to treat it. Your surgeon may also discover a new condition or problem for the first time during the surgery, in which case, the surgeon may need to change the plan for surgery to treat this problem or condition immediately.

I hereby authorize the doctor and/or such assistants as he/she may designate to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Patient Name *(Please Print)*

_____ _____

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