CENTER FOR RETINA & MACULAR DISEASE

Patient Registration Form

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____ SSN: _____

Email Address: _____ Sex: ☐ Male ☐ Female

Florida Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

Secondary Mailing Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____

If insurance is in name other than patient or if patient is a minor, please complete information below:

Policyholder Name: _____

Policyholder Phone Number: _____ Policyholder Date of Birth: _____

I authorize the release of payment for medical benefits to my physician. I authorize the release of any medical information necessary to process all claims.

Patient's Signature: _____ Date: _____

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CENTER FOR RETINA & MACULAR DISEASE

RELEASE OF MEDICAL INFORMATION

Patient Name: _____

By signing below, I authorize Center for Retina and Macular Disease to release my medical and billing information to:

Relationship			Name of Designated Person
Spouse	☐ Yes	☐ No	_____
Children	☐ Yes	☐ No	_____
In-Laws	☐ Yes	☐ No	_____
Caregivers	☐ Yes	☐ No	_____
Parents	☐ Yes	☐ No	_____
Others	☐ Yes	☐ No	_____

We ask that if you have any change in this request, that you please inform our staff

Center for Retina and Macular Disease may leave appointment information on my voicemail:

Home	☐ Yes	☐ No
Work	☐ Yes	☐ No
Relative	☐ Yes	☐ No

Center for Retina and Macular Disease may send appointment information via text:

☐ Yes ☐ No

I authorize the following to pick up prescriptions.

Relationship			Name of Designated Person
Spouse	☐ Yes	☐ No	_____
Relative	☐ Yes	☐ No	_____
Caregiver	☐ Yes	☐ No	_____

Patient Signature: _____ Date: _____

I understand that Center for Retina and Macular Disease will ask for identification of the person picking up patient information or products.

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Center for Retina and Macular Disease
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits, and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment,

payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of- pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund-raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer

Phone number: 863-297-5400

Fax number: 866-463-4799

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which

became effective on **9/23/13**.

CENTER FOR RETINA & MACULAR DISEASE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

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FINANCIAL PRACTICES DISCLOSURE

Welcome to Center For Retina & Macular Disease. Our practice participates in many medical insurance plans. If we are participating providers for your plan, we will file the claim on your behalf. If your plan does not cover the services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, most major credit cards, and Care Credit. Please be sure to provide us with your most current insurance card(s) at each visit and advise us of any changes. Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employee ID as the subscriber number. If you are not the primary cardholder please make sure you give us the correct subscriber (employee) ID number at the time of your visit.

All of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Copayments/Coinsurance/Deductibles: If your plan requires that you pay a copayment, deductible or coinsurance, you are required to pay at the time services are rendered.

Self-Pay Patients: Patients with no insurance are expected to pay at the time of service for all care rendered.

Authorizations/Referrals: Many insurance plans require a referral/authorization for office visits and/or procedures. A referral/authorization from your primary care or referring physician may need to be obtained prior to being seen in our office. We will assist in getting pre-certification or prior approval for your appointment. This is no guarantee of insurance coverage.

Non-Covered Services: On occasion, we may render a service that is not covered by your insurance plan. We make every effort to inform you of this in advance. Any non-covered services will become due and payable by you upon notice from your insurance carrier.

Out-of-Network Services: We make every effort to verify your plan benefits prior to your appointment. In the event that you obtain services by a physician who is not a participating provider with your plan, the amount will become due from you. Please always make sure that the doctors you are treating with participate with your plan.

Affordable Care Plans/Healthcare Exchange: If you have an Affordable Care Plan, you are responsible for paying your healthcare insurance premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, you will be held liable for the amount of the bill for the services rendered by our physicians. This amount will be due in full upon notice.

Outside Collections: if your debt results in a past due status, requiring us to place your debt with our external collection agency, your account will reflect a collection fee of thirty (30) percent added to the amount of debt due.

Your doctor is committed to providing you with the most effective and economical medication for your eye condition. If the recommended medication is a financial burden for you, please inquire whether a lower-cost option is available.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of my personal information, whether medical or otherwise, to release to any third-party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits. I request that payment of authorized health care benefits be paid, and I assign the benefits payable for physician services to the physician or organization furnishing the services. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient/Legal Guardian Signature: _____

Print Name: _____

Date Signed: _____

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SNF PATIENT INTAKE FORM

Are you currently under the care of a Skilled Nursing Facility (SNF)?

☐ Yes ☐ No

Resident Status for Rehabilitation? Circle One

Permanent Temporary

If <u>Temporary Resident</u> provide the following:

Name of Facility: _____

Facility Phone Number: _____

Facility Address: _____

Primary Facility Contact (Nurse Manager / Social Worker):

Name: _____

Phone: _____

Billing Contact / Fax: _____

Does the facility require authorization for visits?

☐ Yes ☐ No

Completed by: _____ Date: _____

SNF FACILITY PARTNER GUIDE

To ensure your residents receive timely and effective retina care, please provide the following:

Required Information:

- Resident full name & DOB
- Facility contact (nurse manager or social worker)
- Billing contact & fax
- Whether authorization is required

Authorization Expectations:

For Medicare Part A residents, certain retina services may fall under consolidated billing.
Please notify our office if authorization is needed prior to the appointment.

Scheduling & Coordination:

Phone: 1-800-472-8867

Please communicate transport arrangements and any mobility needs.

We appreciate your partnership in coordinating retina care for your residents.

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