NC RETINA ASSOCIATES

Patient Registration

PATIENT INFORMATION:

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

Mailing Address: _____ Apt / Ste: _____

City: _____ State: _____ Zip Code: _____

Social Security #:_____ | Gender (Please specify): Male | Female | Other / Decline to Provide

Marital Status (Please specify): Single | Married | Divorced | Separated | Widowed

Race / Ethnic Group: _____

PREFERRED COMMUNICATION:

Phone Number(s): Cell: _____ | Home: _____

☐ Check here if you **PREFER** text message reminders and notifications.
☐ Check here if you authorize NC Retina to leave a voice message.

Email Address: _____

☐ Check here if you **PREFER** email communication reminders and notifications.

Emergency Contact Name: _____

Relationship to Patient: _____ | Phone Number: _____

PRIMARY CARE PHYSICIAN / GENERAL PRACTITIONER:

Provider Name: _____

Practice Name: _____

City: _____ State: _____

Phone Number: _____

☐ I **DO NOT** have a Primary Care Physician / General Practitioner.

NC RETINA ASSOCIATES

Financial Policy

Thank you for choosing North Carolina Retina Associates, PLLC (NC Retina). We are dedicated to providing the highest quality medical eye care in an efficient and cost-effective manner. Please review the following financial policy, which outlines your responsibilities in order to assist us in processing your insurance and medical claims.

NC Retina will file your medical claims with all insurance companies with which we are contracted. While we make every effort to verify your insurance coverage, we do not guarantee the accuracy of the information provided by your insurance company. If incorrect insurance information, provided either by you or your insurance company, delays payment beyond the timeframe allowed to file the claim, you will be responsible for the charges.

PATIENT RESPONSIBILITIES:

- **Insurance Information**
  - You are required to provide current and accurate medical insurance information at each visit. Please show your current insurance card(s) and driver's license.
  - Notify the receptionist of any changes to your personal information, such as your address or phone number.
- **Understanding Your Insurance**
  - You are responsible for understanding your insurance coverage, including co-pays, deductibles, referrals, or other insurance requirements.
- **Referrals**
  - If your plan requires a referral to see a specialist, it is your responsibility to ensure the referral is in place prior to your appointment. Failure to do so will result in you being financially responsible for all services rendered, which must be paid at the time of service.
- **Co-pays**
  - Co-pays are due at the time of service.
- **Remaining Balances**
  - After processing your claim(s) through insurance, any remaining balance will be reflected in a statement mailed to you.
- **Payment Plans**
  - If you are unable to pay in full, you agree to enter into a payment plan and make consecutive monthly payments.
- **Claim Denial**
  - If a claim is denied, you may be asked to contact your insurance company to resolve the denial. If you fail to comply, you assume full responsibility for payment.

SELF PAY POLICY:

Patients without medical insurance are required to pay a deposit at check-in prior to receiving medical care. New patients must pay a $500 deposit for their initial visit. All subsequent visits, including those for established patients, require a $200 deposit at check-in. Any remaining balance due will be reflected on the statement provided.

OUT OF NETWORK INSURANCE POLICY:

NC Retina does not file claims to insurance companies we are not contracted with. If you choose to receive care from our physicians, you will be considered a self-pay patient, and our self-pay policy will apply. If you provide written confirmation of out-of-network benefits, we will provide the necessary documentation for you to file your claim for personal reimbursement.

WORKERS COMPENSATION POLICY:
To file a claim with your workers' compensation or other liability insurance, you must provide complete billing information. If you fail to do so, we will ask for payment in full at the time of service. You will be financially responsible for medical services if the insurance fails to pay in full. NC Retina does not bill attorneys for medical expenses.

PATIENT ASSISTANCE PROGRAMS:
We may enroll qualified patients in assistance programs to help cover the cost of injectable drugs. These programs often require a copay similar to an insurance co-pay. You are responsible for paying this copay on days you receive treatment. Please note that these programs may open and close without notice, and if funds run out, you will be responsible for any unpaid drug coinsurance.

AUTHORIZATION TO RELEASE INFORMATION:
I authorize the release of my medical records, in accordance with applicable laws, to third-party payers and other providers involved in my care. I also authorize any healthcare provider who has treated me to release my medical information to NC Retina as needed for my treatment. I understand that I can revoke this consent at any time, except to the extent that action has already been taken based on my consent.

ASSIGNMENT OF BENEFITS:
I request that payment of authorized Medicare, Medicaid, and all other insurance benefits be made directly to NC Retina for services provided to me. I authorize the release of my medical information to the appropriate entities and their agents to determine the benefits payable for related services.

GUARANTEE OF PAYMENT:
If my insurance has a contract with NC Retina, I am not responsible for amounts that the practice has agreed to write off under the contract. If my insurance does not have a contract with NC Retina, I agree to be responsible for any unpaid amounts. If I fail to make payments, I understand that I am responsible for all costs incurred to collect the debt, including court costs and reasonable attorney's fees. If my account is assigned to a collection agency, I agree to be responsible for collection fees and interest on overdue amounts.

☐ **I acknowledge that I have reviewed and agree to the terms of NC Retina Associates, PLLC's financial policy as outlined above.**

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If applicable, please complete the section below:

Personal Representative Printed Name: _____
Personal Representative Signature: _____
Relationship to Patient: _____

NC RETINA ASSOCIATES

Authorization to Disclose Health Information

I hearby authorize North Carolina Retina Associates, PLLC to release my medical, billing, and/or appointment information to the individual listed below (if you do not request any authorized party to receive your information please leave the below fields blank).

1. Name of Authorized Person:_____

Relationship to Patient:_____

Authorized Information (Please specify): Medical | Appointment | Financial

2. Name of Authorized Person:_____

Relationship to Patient:_____

Authorized Information (Please specify): Medical | Appointment | Financial

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do so by written notification. I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

Notice of Privacy Practices Acknowledgement

I acknowledge, read and understand North Carolina Retina Associates, PLLC's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that North Carolina Retina Associates, PLLC 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.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

If applicable, please complete the section below:

Personal Representative Printed Name: _____
Personal Representative Signature: _____
Relationship to Patient: _____

NAME:_____ DOB:_____ DATE:_____

OCULAR HISTORY

Do you take AREDS2 eye vitamins? YES NO
Do you take any other eye vitamins? YES (Please List)_____NO
Please list any Eye Drops you are CURRENTLY using and **SPECIFY WHICH EYE.**

_____
_____
_____
_____

Previous Eye Surgeries:

_____
_____

Previous Eye Trauma:

_____

Other Eye Diseases:

_____

MEDICAL HISTORY

Have you had your Flu Vaccine this season? YES NO Date: _____
Have you had a Pneumonia Vaccine within the last 5 years? YES NO Date:_____

Do you have Diabetes?

❑ TYPE I ❑ TYPE II

Approximate Year Diagnosed:_____Last Hemoglobin A1C:_____
Physician Managing Diabetes:_____

Please check all that apply:

❑ Seasonal Allergies	❑ Asthma	❑ Thyroid Disease
❑ Acid Reflux	❑ High Blood Pressure	❑ Elevated Cholesterol
❑ Arthritis	❑ Hearing Loss	❑ Cancer
❑ History of Stroke	❑ History of Heart Attack	❑ COPD

Other Medical Conditions not listed above:

_____
_____
_____

SURGICAL HISTORY

Please list any prior surgeries and dates below:

_____
_____
_____
_____

NAME:_____DOB:_____DATE:_____

MEDICATIONS

Preferred Pharmacy:_____

Do you take a blood thinner? YES NO

- ❑ Aspirin
- ❑ Xarelto/Rivaroxaban
- ❑ Eliquis/Apixaban
- ❑ Warfarin/Coumadin
- ❑ Other:_____

Please list ALL medications and vitamins you are CURRENTLY taking with dosages and instructions.

_____

_____

_____

_____

_____

_____

_____

Drug Allergies:

Are you allergic to Iodine? YES NO Are you allergic to LATEX? YES NO

Other:_____

_____

FAMILY HISTORY

- ❑ Blindness Relationship:_____
- ❑ Retinal Detachment Relationship:_____
- ❑ Macular Degeneration Relationship:_____
- ❑ Glaucoma Relationship:_____
- ❑ Diabetes Relationship:_____
- ❑ Cancer Relationship:_____
- ❑ Stroke Relationship:_____
- ❑ Heart Disease Relationship:_____

SOCIAL HISTORY

Are You:

- ❑ Not Working/Disabled
- ❑ Retired
- ❑ Working

Occupation:_____

Tobacco Use:

- ❑ NEVER SMOKER
- ❑ CURRENT SMOKER
- ❑ FORMER SMOKER

Date Quit:_____

Alcohol Use:

- ❑ NONE
- ❑ Occasional/Social
- ❑ 1-2 Drinks Daily
- ❑ 3-4 Drinks Daily

Illicit Drug Use: YES NO If Yes, Please Explain:_____

Are you pregnant or trying to conceive? YES NO

Have you been exposed to a Sexually Transmitted Infection? YES NO _____