PATIENT INFORMATION SHEET

☐ Miss
☐ Ms.
☐ Mrs.
☐ Mr.

PATIENT'S NAME _____ ☐ Male ☐ Female

ADDRESS _____

CITY _____ STATE_____ ZIP_____

BIRTHDATE _____ AGE_____ SOCIAL SECURITY _____

HOME PHONE _____ WORK PHONE_____

E-MAIL _____

By providing your e-mail address, you will be invited to participate in the Patient Portal for your Retina summary. Once you receive this e-mail, you have the option to accept or decline. Your e-mail address will not be used for any other purpose.

PREFERRED LANGUAGE
☐ English
☐ Spanish
☐ Other (_____)

RACE
☐ White
☐ Black
☐ Asian

ETHNICITY
☐ Hispanic
☐ Non-Hispanic

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____

PCP ADDRESS _____

PCP PHONE _____

EMERGENCY CONTACT PERSON _____ PHONE # _____

INSURANCE INFORMATION

INSURANCE NAME _____

INSURANCE ID# _____

WORKER'S COMP ☐ Yes ☐ No

If patient is under 18 Mother_____ Father_____

To comply with Government Protocols, Retina Associates of Western New York is now enrolled in an electronic prescribing program. To better assist with your care, this program allows the practice to download your medication history from a centralized pharmacy database and it allows us to transmit your prescription to the pharmacy of your choice.

PATIENT SIGNATURE _____ Date_____

PHARMACY NAME _____

PHARMACY ADDRESS _____

PHARMACY PHONE NUMBER _____

COPAYMENT / DEDUCTIBLE REQUESTED AT TIME OF SERVICE

THANK YOU

OVER

Signature on File, Assignment of Benefits, Financial Agreement

Name (Print) _____ Insurance # or/ Medicare # _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Retina Associates for services furnished to me by Dr. _____. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer shown. Retina Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

1. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Retina Associates.

2. **RELEASE OF INFORMATION:** Retina Associates may disclose all or any part of my medical records and/or financial ledge, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contact to Retina Associates for reimbursement for services rendered and (2) any health care provider for continued patient care. Retina Associates may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

3. **OTHER INSURANCE:** I understand that Retina Associates maintains a list of health care service plans with which it contracts. A list can be available to me. Retina Associates has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Retina Associates if I belong to a plan that does not appear on the above mentioned list.

4. **NON COVERED SERVICES:** I understand that Retina Associates contracts with health care service plans (i.e., HMO's, PPOs) state items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient, and treatment or tests not authorized by the health care service plans. The undersigned agrees to cooperate with Retina Associates to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Retina Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Retina Associates for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Retina Associates. If copayments and or deductibles are designated by my insurance company or health plan, I agree to pay them to Retina Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signature or Authorized Party _____ Date _____