SOUTHEASTERN RETINA SPECIALISTS

Patient Name: _____ **DOB:** _____

Street Address: _____ **Gender:** _____

City, State, Zip: _____ **Home Phone #:** _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ***Cell Phone #:** _____

Do you authorize Southeastern Retina Specialists to send you appointment notifications via text messaging?* ☐ ***Y* *or* ☐ ***N***

Social Security #: _____ **Work Phone #:** _____

E-Mail Address: _____

Employer Name: _____ **Employer Phone #:** _____

Is this appointment the result of an accident or injury? ☐ **Y*** or ☐ **N**

*If Yes, please provide the claim # and adjustor information for this appointment.

Note: The information requested below is a reporting requirement of the government Patient Protection and Affordable Care Act 2010. We are obligated to obtain this information from our patients.

Race:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other - _____

Ethnicity:

- ☐ Hispanic
- ☐ Not Hispanic
- ☐ Other - _____

Preferred Language:

- ☐ English
- ☐ Other - _____

Primary Insurance

Carrier Name: _____ **Insurance ID #:** _____

Carrier Phone #: _____ **Group #:** _____

Carrier Address: _____

Are you the SUBSCRIBER **or the** DEPENDENT **for this plan?** _____

Secondary Insurance

Carrier Name: _____ **Insurance ID #:** _____

Carrier Phone #: _____ **Group #:** _____

Carrier Address: _____

Are you the SUBSCRIBER **or the** DEPENDENT **for this plan?** _____

If you are the DEPENDENT **on any insurance plan listed above, please complete the following information:**

Subscriber Name: _____ **Relationship:** _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Emergency Contact

Name: _____ **Phone #:** _____ **Relationship:** _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private or government insurance and other health plans to the party who accepts assignment. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described. This assignment will remain in effect until revoked by me in writing. I authorize the release of any medical or other information necessary to process this claim.

_____ _____

Signed (Insured or Authorized Individual) **Date**

SOUTHEASTERN RETINA SPECIALISTS

LIFETIME INSURANCE ASSIGNMENT AND AUTHORIZATION FORM

Southeastern Retina Specialists, PA (SRS) is pleased to file your insurance on behalf of each patient. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

I hereby instruct and direct my past and/or present insurance company to issue payment(s) directly to: **Southeastern Retina Specialists, 7740 Point Meadows Drive, Suite 3A, Jacksonville, FL 32256** of benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for all medical, surgical and diagnostic services rendered by SRS. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to SRS and I agree to pay, within ninety (90) days of the date of the first monthly bill, any balance of said charges over and above insurance payment(s), including applicable copayments, deductibles, co-insurances, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to SRS. A photocopy of this assignment shall be as effective and as valid as the original. Furthermore, I understand that SRS accepts Medicare assignment and Medicare payments will be directed to SRS. I authorize SRS to use or disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement. I authorize SRS to fax the results of my evaluations to my referring physician, if appropriate.

I further agree and acknowledge that:

- Should I decline to sign this Lifetime Insurance Assignment and Authorization Form, I assume full responsibility for all charges incurred for services provided at SRS and that these charges are due in full at the time of service.

This Lifetime Insurance Assignment and Authorization is ongoing and will not expire until such time as written notice of revocation is provided.

_____ _____

Signature of Patient or Legal Representative **Date**

CONSENT FOR MEDICAL INFORMATION RELEASE

There are times we are asked to release your healthcare information to family members or other individuals, including but not limited to, test results, appointment information, diagnoses and treatment plans, and/or billing information. If you would like for us to release your information to any other individual, please list those person(s) below and their relationship to you. Please make notes as necessary.

_____ _____

Name of Person **Relationship**

_____ _____

Name of Person **Relationship**

_____ _____

Name of Person **Relationship**

☐ **NO INFORMATION TO BE RELEASED** (Please INITIAL box)

This consent to release information will remain in effect until revoked in writing.

_____ _____

Signature of Patient or Legal Representative **Date**

Notice of Privacy Practices
Patient Acknowledgement

I have received Southeastern Retina Specialists' Notice of Privacy Practices written in plain language. This notice provides, in great detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice on request.

Signing this acknowledgement does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgment does not prevent the practice from using or disclosing health information as the Rule permits it to do. If you refuse to sign this acknowledgment, the practice must keep a records that they failed to obtain your acknowledgement.

_____ _____

Patient Signature Date Signed

Relationship to patient: _____
(If signed by a personal representative of patient)

Patient Name: _____ DOB: _____

SOUTHEASTERN RETINA SPECIALISTS

FINANCIAL PRACTICES DISCLOSURE

Welcome to Southeastern Retina Specialists. Our practice participates in many medical insurance plans. If we are participating providers for you plan, we will file the claim on your behalf. If your plan does not cover 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, social security number, 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. You will need to obtain this referral/authorization from your primary care or referring physician prior to being seen in our office. If you are having surgery we will assist in getting pre-certification or prior approval for your procedure.

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: During the transitional period associated with starting a new practice, we will make every effort to work with your insurance company to obtain authorization for your care with the same in-network benefits that you currently have. In most cases, this is not a problem and your insurance carrier will allow us to treat you just as if we were an in-network provider. If there is an instance where this is not possible, we will make whatever adjustments necessary so that you are not charged anything more than if you had seen an in-network provider. Please know that we are making every effort to become participating with the primary payers in our region. Unfortunately, the process can sometimes be lengthy. We will keep you informed!

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.

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.

X _____ _____

Patient Signature **Date Signed**

Relationship to patient (If signed by a personal representative of patient)**:** _____

Patient Name: _____ **DOB:** _____

07/15 JD

SOUTHEASTERN RETINA SPECIALISTS

Today's Date: _____

Patient Name: _____ **DOB:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Major Surgeries: _____

_____

Allergies: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Medical Condition *(Circle All That Apply)* If **Other**, please provide as much detail as possible	**M - Mother** **F - Father** **GP - Grandparent** **S - Sibling** **P - Patient**	**Details / Explanation**
Eyes: Injury, Retinal Detachment, Glaucoma, Cataract, Macular Degeneration or Hole, Laser, Injections, Blurry Vision, Double Vision, Loss of Side Vision, Flashes and/or Floaters, Distortion, Wavy Lines, Dryness, Tearing, Itching, Redness, Pain, Halos, Other		
General / Constitutional: Fever, Weight Gain/Loss, Fatigue, Other		
Ear, Nose & Throat: Sinusitis, Hearing Aid, Chronic Cough, Dry Mouth, Other		
Cardiovascular: Heart, High Blood Pressure, Vessels, Heart Attack, Stroke, TIA, Other		
Respiratory: COPD, Emphysema, Asthma, TB, Other		
Gastrointestinal: GERD, Ulcers, Colitis, IBS, Acid Reflux, Other		
Genital, Kidney & Bladder: Enlarged Prostate, Incontinence, Renal Failure, Other		
Muscle & Skeletal: Gout, Arthritis, Joint Pain, Osteoporosis, Other		
Skin & Integumentary: Skin Cancer, Acne, Warts, Psoriasis, Other		
Neurological: Multiple Sclerosis, Parkinson's, Alzheimer's, Dementia, Stroke, TIA, Other		
Endocrine: Diabetes/Sugar, Thyroid		
Blood & lymph: Cholesterol, Anemia, Hemophilia, Sickle Cell, Other		
Psychiatric: Anxiety, Depression, Insomnia, Other		
Allergic & Immunologic: Allergies, Lupus, Sjorgen's, Other		
Hepatitis C, HIV, AIDS		
Cancer - Type & Location		
Have you ever received a blood transfusion?	**Y** or **N**	

Today's Date: _____

SOCIAL HISTORY

Patient Name: _____ **DOB:** _____

Current Occupation: _____

Education: High School College Degree Vocational School Other

Marital Status: **S**ingle **M**arried **D**ivorced **W**idowed **Do you have a living will?** **Y** or N

Student: **Y** or **N** **Retired:** **Y** or **N** **Do you currently drive?** **Y** or **N**
(Full Time / Part Time)

Tobacco Use (circle one)**:** **Never** **Current** **Former** **Quit Date:** _____
Type: _____

Alcohol Use: **Y** or **N**
Frequency: _____

Last Flu Shot: _____ **Last Pneumonia Vaccine:** _____

Do you have any special living arrangements? Assisted Living Wheelchair Walker Other

Please list any other Personal and/or Family Medical History and/or Social History you would like our physician(s) to be aware of when treating your condition: _____

----------FOR OFFICE USE ONLY----------

Updated By:	Date:	Updated By:	Date:	Updated By:	Date:

SOUTHEASTERN RETINA SPECIALISTS

Today's Date: _____

PRESCRIPTION, OVER THE COUNTER AND SUPPLEMENT MEDICATION LIST

Patient Name: _____ **DOB:** _____

Pharmacy Name & Phone #: _____

Drug Allergies: _____

Primary Care Physician Name & Phone #: _____

DRUG NAME (Please print)	**DOSAGE**	**FREQUENCY**	**ROUTE** (Oral, Nasal, IM, Drops, Topical, Suppository)	**ADD / DC DATE**

***** If additional space is needed, please print an additional sheet or request one from the front desk *****

----------FOR OFFICE USE ONLY----------

Updated By:	**Date:**	**Updated By:**	**Date:**	**Updated By:**	**Date:**