5150 N. Davis Highway
Pensacola, FL 32503

retinaspecialty.com

Toll-free
855.5RETINA
Fax 850.484.5222

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Health Information Privacy Practices, which provides a complete description of health information uses and disclosures. I understand that I have the following rights and privileges.

The right to review the notice prior to signing this consent
The right to object to the use of my health information for directory purposes
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, Retina Specialty Institute will no longer use or disclose medical information about me for the reasons covered by my written authorization. I understand that Retina Specialty Institute is unable to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me.

I further understand that if I choose to revoke my consent, Retina Specialty Institute may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

By signing this document, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices.

______________________________ ____ __________________
Print Name Signature Date

With your permission, Retina Specialty Institute may release your protected health information to a family member or another person involved in your care or payment for your care.

Please identify the person or persons who are involved in your care of the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name: _________________________ Relationship: __________________ Date of Birth: ___________

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Name: _________________________ Relationship: __________________ Date of Birth: ___________

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Please Print Clearly

Name: ______________________________

Address: ______________________________

City: ______________ State: _____ Zip: ______

Home Phone: ______________________________

Cell Phone: ______________________________

Social Security Number: ____________________

Date of Birth: ______________ ☐Male ☐Female

☐ Single ☐ Married ☐ Other: ____________

Preferred Language: ____________________

Ethnicity: __ Hispanic Origin __ Non-Hispanic Origin

Race: __American Indian or Alaskan Native

__White __Asian __Black / African American

___Native Hawaiian or Pacific Islander

Referred by: ______________________________

Family Doctor: ______________________________

Parent/Spouse: ______________________________

If Patient Is a Minor, Authorized By:

Signature: ______________________________

Employer: ______________________________

Work Phone: ______________ Ext.: ________

Email Address: ______________________________

In Case Of Emergency Notify: ______________

Relationship: ______________________________

Emergency Phone: __________________________

INSURANCE

Primary Insurance: ________________________

Name on Insurance Card: ____________________

Insured's Date of Birth: ____________________

Relation to Patient: ________________________

Policy #: ______________ Group #: ____________

Secondary Insurance: ______________________

Name on Insurance Card: ____________________

Insured's Date of Birth: ____________________

Relation to Patient: ________________________

Policy #: ______________ Group #: ____________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with the carrier(s) stated above and assign directly to Retina Specialty Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

If your insurance is an HMO, your HMO requires that your primary care doctor provide a referral to the physician who is providing your ophthalmology care. It is your responsibility to obtain authorization in advance of your appointment (at least 24 hrs.). Your doctor may mail/fax it to our office or you may bring it to your visit. Contact us if you require any assistance in obtaining the authorization. We will be happy to help in any way possible. If an authorization is not obtained from your HMO prior to the delivery of care, we will expect you to accept financial responsibility for any charges. You will be sent a bill from the billing office for physician services provided to you. I have read the statement above and I understand that I will be billed and am responsible for payment for the professional and facility fees for services provided to me in the event that my HMO does not authorize these services.

Signature of Patient: ______________________________ Date: ______________

Responsible Party Signature: ______________________ Relationship to Patient: ____________

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Medical History Questionnaire

Name: ____________________ Birth Date: ______________ Referring Doctor: ____________________

List any medications you routinely take: ____

____

Allergies to medications: ____

____

Do you **presently** have any of the following symptoms?

	YES	NO
Blurred Vision	☐	☐
Chest Pain	☐	☐
Diarrhea	☐	☐
Fatigue	☐	☐
Headache	☐	☐
Dizziness	☐	☐
Pain in Joints	☐	☐
Paralysis of Extremities	☐	☐
Shortness of Breath	☐	☐
Runny Nose	☐	☐
Sore Throat/Cough	☐	☐
Bloody Stools	☐	☐
Fever	☐	☐
Nausea/Vomiting	☐	☐
Pain with Urination	☐	☐
Frequent Urination	☐	☐
Rash	☐	☐
Sudden Vision Loss	☐	☐

Any diseases in the family? If "YES," please indicate **relationship** to you.

	YES	NO
Blindness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Attacks	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

Indicate your **past** or **present** medical history:

	YES	NO
Blindness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Cardiac/Vascular Disease	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
High Blood Pressure	☐	☐
Kidney Stones	☐	☐
Stomach Ulcer	☐	☐
Asthma/Emphysema	☐	☐
AIDS/HIV	☐	☐

List **any surgeries** you have had in the past:

____

____

____

Do you smoke? YES ☐ NO ☐ Pack(s) a day: ______

If no, did you smoke in the past? YES☐ NO ☐

Do you drink alcohol? YES ☐ NO ☐

Number of glasses a day: ________

Present occupation: ____________________

Education: (please circle one)

High School College Post-graduate

Do you drive? YES ☐ NO ☐

Are you married? YES ☐ NO ☐ Other: ________

Other important information:

____

____

Patient Signature: ____ Date: ______________

Doctor Signature: ________________________ Date: __________ ☐ Reviewed information with patient

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Retina Specialty Institute. We are committed to the treatment, preservation and advancement of your retina care. Please understand that payment of your bill is considered part of your retina care. The following is a statement of our **Policy**, which we require that you read and sign before being seen by one of our physicians.

Your Responsibility:

You are financially responsible for the services we provide to you. We understand that many patients arrange for health insurance plans to pay for a large portion of their medical expenses. However, the patient or legal guardian is responsible to pay our fees for all examinations and treatments in the office or in surgery, in the event that your insurance carrier deems our services non-covered or not payable.
As a courtesy to you, we will file a claim to your insurance plan(s). However, we do expect payment of co-payments, (co-insurance, deductible, non-covered services/drugs, etc.) at the time services are rendered. Payments will be collected either before or after the appointment. If you are unsure of your financial responsibility, please contact your insurance plan in advance to obtain this information.
Please remember your insurance benefits is a contract between you and the insurance carrier, we will assist in filing any of your claims for you, but will look to you for assistance in expediting our claims in a timely manner.
Our insurance billing specialists are available to help with assistance you may require, and to help with an estimate of your financial responsibility.

Non-Covered Service Condition

Retina Specialty Institute is dedicated to the preservation and treatment of your retinal condition. Since we are a specialty practice, some procedures that may be performed in your treatment plan could be deemed non-covered by your insurance plan. As a courtesy to you, we will file the services to your insurance carrier for consideration of reimbursement. In the event that these services are determined to be a non-covered service by your benefit plan, it is your responsibility to pay for the services rendered. Our financial counselors are available to you to review these out of pocket expenses with you prior to services being rendered.

Prior Balance

Patients with a balance from prior services rendered will be required to pay that balance in full before being seen by our physicians. If the prior balance cannot be paid in full, you will be asked to speak to our financial counselors to make payment arrangement determinations based on our payment policy before being seen by the physician.

Patient without Insurance Coverage (Self-Pay)

Retina Specialty Institute is pleased to be able to provide services to patients that do not have insurance coverage. However, if you do not have insurance you will be expected to pay:

1. **minimum deposit of 1/3 of the estimated charges due the same day services are rendered**
2. **1/3 of the balance will be due no more than 15 days from the date services are rendered**
3. **the balance will be due in full no more than 30 days from the date services are rendered.**

If you are unable to pay the balance in full within the 30 day time period from the date services are rendered, please contact our financial counselors to ascertain how the debt will be paid.

Methods of Payment

We accept Cash, Checks, Visa, MasterCard, Discover and American Express. We now accept all Health Savings Account debit cards. We do not accept post-dated checks; nor will we hold checks for any length of time.

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Returned Checks

We assess a $30.00 fee on checks that have been returned by our bank for "non-sufficient funds". We expect payment of the bank fee and the returned check before the next appointment.

Medicare Patients

Retina Specialty Institute accepts Medicare assignment. We will file to your secondary and/or supplemental insurance, if you have provided us with the proper billing information. You are responsible for the applicable co-insurance, deductible and non-covered services and injectable drugs. In addition to the bill we send to you, Medicare will also provide you an Explanation with detailed information indicating the amounts you will owe.
If you do not have any secondary and/or supplemental insurance, you are responsible for the balance after Medicare.

Medicaid Patients

Retina Specialty Institute accepts Medicaid assignment. A current Medicaid card must be presented at each visit. You will be responsible to pay the co-pay at the time of check-in. If you have exceeded the legislative limits for the year as set forth by Medicaid, you will be responsible to pay all charges for services performed. If you have a Medicaid product that requires prior authorization it is your responsibility to bring your referral from your Primary Care Physician with you to the appointment. If you have the Medically Needy Medicaid product, it is your financial responsibility to pay any out of pocket expense until the share of cost is met.

Medicare Advantage (Replacement Part C)/Medicaid Patients

If you are enrolled in a Medicare Advantage plan or a Medicare Replacement plan, also known as Medicare Part C, with Medicaid as the secondary payer, you are responsible for co-payments, co-insurance, deductibles and non-covered services and injectable drugs. Medicaid does not have approved funding to pay any balances remaining from these types of policies. It is the responsibility of the patient to pay these remaining balances. We will not file these balances to Medicaid as they do not pay for these amounts.

Workers Compensation

Retina Specialty Institute accepts Workers Compensation Insurance. It is your responsibility to provide the following information to our office prior to services being rendered:

1. **Name of your employer**
2. **Contact name and number for your employer**
3. **Date of injury**
4. **Claim number if available**

Any other information that will help to expedite the handling of your claims filing process.
Failure to provide this information will result in the patient being responsible for all services rendered.

HMO Patients

If Retina Specialty Institute participates with your insurance plan, you will be required to pay for the applicable co-pay, co-insurance and/or deductible at the time services are rendered. When required by your HMO plan, you are responsible for obtaining a referral from your Primary Care Physician. If you do not have a proper referral/authorization you may be required to reschedule your appointment. If services are rendered without a valid referral/authorization, you will be expected to sign a "Waiver" and must pay under the conditions of a non-covered service.

1. **minimum deposit of 1/3 of the estimated charges due the same day services are rendered**
2. **1/3 of the balance will be due no more than 15 days from the date services are rendered**
3. **the balance will be due in full no more than 30 days from the date services are rendered.**

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Liability Insurance

If you are involved in an accident, we will be pleased to provide medical care for you. However, we are only able to file claims to liability insurance carriers involving auto accidents. We do not file claims to third party liability carriers.
We ask that in addition to your auto insurance information, you provide us with copies of your health insurance plan as well, any balances remaining after your auto insurance carrier will then be filed to your health insurance plan.

Private Pay Insurance

Retina Specialty Institute defines Private Pay Insurance as a policy that reimburses the patients for any medical treatments they have received, i.e. cancer policies, office visit reimbursement policies, etc. We will be pleased to provide you the necessary documentation to file to these plans, however we require that any unpaid balances be paid in full before we provide you these documents.

Minor Patients

The accompanying adult/guardian is responsible to pay for services rendered to a minor patient. It is the responsibility of the person bringing the minor into the office to obtain reimbursement from any other source or parent. We will not bill another person regardless of any legal documents; it is the responsibility of the person with the minor patient at the time of service to resolve any issues with other parties.

Information Change

We ask that you please keep us informed of any updates to addresses, telephone numbers, and any changes to insurance plans.

Collection Agency

Prompt payment of patient financial responsibility is expected per the terms of this agreement. We will use an outside collection agency for patient balances as we deem necessary. Failure to resolve outstanding patient balances may result in discharge from care by our physicians. Prior balances must be resolved before the practice will provide new services. A late fee will be added to any balances that are turned over to an outside collection agency.

I have read and understand the financial policy of Retina Specialty Institute. I agree and understand the terms and conditions of this policy, I also agree that any questions I have, have been answered by the financial counselors to the best of my understanding:

______________________________________ ______________________

Signature of Patient or Guardian of a Minor Date

____

Print Name of Patient