RETINA GROUP OF TEXAS

Patient Information

First Name _____ MI _____ Last Name _____

Date of Birth _____ Sex ☐ Male ☐ Female SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ ☐ Preferred? ☐ Voicemail OK?

Cell Phone _____ ☐ Preferred? ☐ Voicemail OK? ☐ Text OK?

Email *for patient portal or appointment reminders* _____

Race ☐ White ☐ Black/African American ☐ American Indian
☐ Asian ☐ Native Hawaiin/Other Pacific Islander ☐ Decline

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Occupation _____ Employer _____

Referral doctor _____ Family doctor _____

Emergency contact _____

Relationship to patient _____ Phone _____

If patient is on Medicare, are you under care by a Skilled Nursing Facility (SNF)? ☐ Yes ☐ No

If patient is minor or dependent, Name of Responsible Party

Relationship to patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Please provide signed Power of Attorney document, if applicable

Authorization to Disclose Protected Health Information

I authorize the following person to discuss my medical care and billing information on my behalf.

Name _____ Relationship _____

Name _____ Relationship _____

RETINA GROUP OF TEXAS

Patient Financial Responsiblity

It is important for patients to understand what is expected regarding payment of medical services. The following is our financial policy. Some of these items are required by law.

1. All co-pays, co-insurances, and deductibles required by your insurance company must be paid at the time services are rendered. An estimate of your financial responsibility will be prepared by our office prior to each visit.
2. A credit card will be required to be on file for each patient ("card on file"). This credit card information is safely stored on an encrypted database.
3. If you do not have insurance, payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.
4. It is the your responsibility to be aware of the contract benefits of your insurance carrier or any co-pay, co-insurance, and deductible obligation. If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.
5. If there is a balance on your account, you will receive a statement from our office within 1 month of your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

If you have any questions about the above financial responsibilities, please speak with our billing staff.

Patient Signature _____

Treatment Authorization

I authorize the physicians and staff of Retina Group of Texas to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my physician during any and all visits. I understand that I am financially responsible for all charges for services rendered to me by the physicians and staff of Retina Group of Texas.

Patient Signature _____

Acknowledgement of Notice of Privacy Practices

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

By signing this form, you acknowledge that you have received a copy of our *Notice of Privacy Practices* and have had an opportunity to read it, I also understand that I may speak with the Privacy Officer if I have any questions.

Patient Name _____

Patient Signature _____ Date _____

RETINA GROUP OF TEXAS

Card on File Policy

We are committed to making the billing process as simple as possible. As you may know, the current healthcare market has resulted in insurance plans increasingly transferring costs to you, the patient. Many insurance plans require co-pays, co-insurance, and deductibles in amounts that are not always fully known to you, or to us, at the time of your visit. **To make managing payments easier for both our patients and our staff, we require that you place a credit card on file at the time of check-in.** A valid credit card, debit card, or HSA/FSA card will be accepted.

Our electronic health record, Nextech, stores card information in an encrypted format on a secure database. We are under strict state and federal guidelines to protect patient privacy and your card on file is considered protected health information. Office personnel will not have access to your card information. Only the last 4 digits of your card number will show in our system.

Here is how it works:

1. Prior to each visit, we will collect any known co-pays, co-insurance, and deductible amounts as usual. These amounts are kept as a pre-payment credit on your account.
2. Once your insurance company has processed our claim, they will send an Explanation of Benefits (EOB) to both you and us. The EOB will show what your total patient responsibility is. If you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier.
3. If there is a remaining patient balance after pre-payment credits are applied, our billing service will charge your credit card on file for the remaining amount up to a maximum of $250. However, if there is a balance in your favor, we will promptly refund the balance back to your credit card.

Please see our Card on File "Frequently Asked Questions" for further information.

Card on File Authorization

I authorize and request Retina Group of Texas to charge my card for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that a copy of my credit card will be kept on file. If my credit card declines, I will provide a new credit card number. This authorization will remain in effect until I cancel this authorization. To cancel, the account must be in good standing.

Patient Name _____

Patient Signature _____ Date _____

RETINA GROUP OF TEXAS

Card on File: Frequently Asked Questions

"Why the change?"

Nothing is changing about how much you pay. When you come to our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care. To be sure that patient balances are paid in a timely manner, we need to have a guarantee of payment on file in our office. We have wonderful patients and we know most of you pay your balances. Unfortunately, that is not always the case. Although this policy may be surprising to you, we are not the first medical practice to enforce this policy, and you will begin to see it more and more.

"I've never had to do this before at any other doctor's office."

This may be different from what you are used to, but it is not uncommon in many medical practices, imaging centers, outpatient surgical centers and outpatient laboratories to require a card on file. This is similar to hotels and rental car agencies that require a credit card to be kept on file.

"What are the benefits to me?"

Convenience. Patients who have a credit card on file will no longer have to worry about statements and mailing in payments. You can also use it to pay for future visits without having to bring your card to each visit. Having a credit card on file will make check-in and check-out easier, faster, and more efficient. Our office staff can spend our time on things we think are more important, like helping patients on the phone and in-person, following up with insurance claims, and working to make your visit the best it can be.

"What if I do not have a credit card?"

A valid credit card, debit card, health savings account (HSA) card or flexible spending account (FSA) card will be accepted.

"What if I need to dispute my bill?"

We will always work with you to understand if there has been a mistake. We will only charge the amount that we are instructed to by your insurance plan in the EOB they send to us. Should your card be mistakenly run, we will refund your card.

"What if I have more questions?"

Our staff is available to speak with you about your account at any time during regular business hours.

RETINA GROUP OF TEXAS

Medical History

Eye Conditions and Previous Surgeries ☐ None

☐ Retinal Detachment ☐ Retinal Vein Occlusion ☐ Corneal Disease
☐ Macular Degeneration ☐ Iritis or Uveitis ☐ Glaucoma
☐ Diabetic Retinopathy ☐ Cataracts ☐ Other:

Current Eye Medications ☐ None

Medical Conditions and Previous Surgeries ☐ None

☐ High Blood Pressure ☐ Asthma ☐ Thyroid Disease
☐ Diabetes ☐ Migraines ☐ Sinus Problems
☐ Arthritis ☐ Heart Disease ☐ Other:

Current Medications ☐ None

Allergies ☐ No known drug allergies

Family Eye History ☐ None

☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma
☐ Other:

Social History

Do you smoke? ☐ Yes ☐ Former ☐ Never *If yes*, how often?