RETINA CONSULTANTS

Patient Registration

Dr Mr Mrs Miss Ms______________________ Date__________
Home telephone:( )______________ Work telephone: ( )__________
Cell phone: ( )__________
Address:______________________________________
City:______________ State:__________ ZIP:__________
My email address is:______________ ❑ I have no email address
I am interested in receiving Electronic Health Records and/or educational material via email:
❑ Yes ❑ No
Sex: M F Marital Status: Single Married Divorced Widowed Separated
Social Security:______________ Date of birth:__________Age:____
My optometrist is__________ **My primary MD is** __________
Referred by:______________
Emergency contact name______________relationship__________
Emergency contact phone__________ other phone__________

Insurance Information: We will copy your insurance card(s)
My Primary Health Insurance is:______________________
Subscriber **if not self**______________ Date of birth__________
Social Security #______________ Relationship__________

My Secondary Health Insurance is:______________________
Subscriber **if not self**______________ Date of birth__________
Social Security #______________ Relationship__________

The information above is true and correct to the best of my knowledge.
I understand that both of my pupils will be dilated at *every* visit, and that I should not operate a motor vehicle (if otherwise able) for 4-6 hours until the dilation wears off.

____
patient signature

(OVER)

Retina Consultants of Indiana and Ohio Consent Form

All Patients: Collection Fee Responsibility Notice

In consideration of the services provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge, or, if no such arrangements are made, then payment shall be made in full within thiry (30) days of discharge. I/we agree that in the event of default in payment, reasonable costs of collection, equal to fifty (50) percent of the delinquent balance, and/or reasonable attorney fees may be added to the amount due on the account.

Patient signature ______________________ Date ______________

All Patients with Insurance

I declare that I have listed all of the medical health insurance plans from which I receive benefits. I request that the payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Retina Consultants of Indiana and Ohio, LLC for any services provided me by Dr. Rapkin or the other caregivers of Retina Consultants of Indiana and Ohio LL. I authorize any holder of pertinent information about me to release to insurance carriers and Health Care Financing Administration (HCFA) or other government agencies or their agents such information required to determine the benefits payable for related services.

Patient signature ______________________ Date ______________

Patients with Medicare Insurance (and secondary coverage)

I request that the payment of authorized MediGap benefits be made on my behalf to Retina Consultants of Indiana and Ohio LLC physicians for any services provided me by Retina Consultants of Indiana and Ohio LLC physicians. I authorize any holder of medical information about me to release to any insurance or coverage provider any information needed to determine the benefits payable for related services.

Patient signature ______________________ Date ______________

All Patients without Insurance benefits (self-pay)

I understand that I am fully responsible for payment of all charges for services incurred on my behalf or on the behalf of the patient for whom I am responsible. I agree to pay a deposit of $300 no later than the day of my first visit and payable before I am seen by the doctor. I agree to pay for any required surgical procedures in full before the day of surgery unless other arrangements are made in advance.

Patient signature ______________________ Date ______________