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 other (specify) _____ 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:

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)

All Patients: Collection Fee Responsibility and Returned Check Fee 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. A $25 fee will be charged for any returned checks.

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