



## Patient Registration

We require copies of all insurance cards (including Medicare cards) as well as a picture ID. Please present these to the front desk.

**Patient Name:** \_\_\_\_\_  
(Last, First, Middle)

**Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Language Preferred:** \_\_\_\_\_

**Birth Sex:**  Male  Female  Undifferentiated

**Gender:**  Male  Female  Other \_\_\_\_\_

**Race:** (check all that apply)

- American Indian or Alaska native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Decline to Specify
- Unknown
- Other \_\_\_\_\_

**Ethnicity:** (check one)

- Not Hispanic or Latino
- Hispanic
- Decline to Specify
- Other \_\_\_\_\_

**Home Phone:** ( ) \_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Patient Email Address:** \_\_\_\_\_

**Preferred method for appointment reminders:**  Call  Email  Text

**Patient Social Security Number:** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Employer:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Third Insurance:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

If your insurance coverage is through a spouse or other family member, you must fill out this section completely

Subscriber Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_\_\_

Contact Phone: (    ) \_\_\_\_\_

Employer Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy: \_\_\_\_\_

Are you currently staying in a skilled nursing facility?     No     Yes

Is this a Workers Compensation Injury?

No     Yes-Complete WC Form

Is this an Auto Accident Injury?

No     Yes-Complete Auto Injury Form

Referring Physician: \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_

**In Case of Emergency** – Please list the nearest relative/friend we may contact (not living with you).

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Acknowledgement of Receipt of Notice**-I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

- I would like to receive a copy of any amended Notice of Privacy Practices.
- I would **NOT** like to receive a copy of any amended Notice of Privacy Practices.

**Information Regarding Dilation Eye Drops** - Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize the doctors at the Retinal Consultants and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

**Consent for Method of Contact** - Patients in our practice may be contacted via email and/or text messaging to be reminded of an appointment, to obtain feedback on patient experience, and/or to provide general health reminders/information. By signing below, I consent to receive emails or text messages from the practice for communication as stated above. I understand that the request to receive emails and text messages for appointment reminders will apply to all future appointment reminders unless I request a change in writing.

**Consent for Recorded Conversation** – Retinal Consultants may record my encounters and use the recording to transcribe into my electronic health record. By signing below, I consent to our recording of the conversation in the exam room for use in the documentation of your visits with your physician.

**Information Regarding the Open Payments Database Acknowledgement-** The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>. The federal Physician Payments Sunshine Act requires that detailed information about payments worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. By signing below, I acknowledge that I have been informed of the Open Payments database.

**Insurance Authorization and Assignment and Financial Policies** - Our policies regarding billing and payment are detailed below. We reserve the right to reschedule routine appointments when payment is not available at time of service.

**Insurance Authorization and Assignment** - I request that payment of authorized benefits be made either to me or on my behalf to Vitreo-Retinal Medical Group, Inc. (Retinal Consultants Medical Group) or Northern California Advanced Surgery Center LP for any services furnished to me by that physician or Vitreo-Retinal Medical Group, Inc. or Northern California Advanced Surgery Center LP. I authorize any holder of

**For Office Use Only: MRN #:** \_\_\_\_\_

medical information about me to release to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, the physician or Vitreo-Retinal Medical Group, Inc. or Northern California Advanced Surgery Center LP agrees to accept the charge determination of the payer as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

**Patients with Insurance-** We contract with many but not all insurance plans. Please verify with your insurance carrier if we are contracted with your insurance plan. If you receive treatment from a doctor that is not contracted with your insurance or is considered out-of-network, the insurance may pay at a lower rate or nothing at all. The remaining balance will be your responsibility. You understand that you are responsible for any amounts due to providing false or incorrect insurance information. Your insurance company mandates that we collect co-payments at the time of your visit unless you have enrolled in our Auto Payment Collect Program.

**Private Pay Patients-** If you do not have insurance, please be prepared to pay for your visit at the time of service. If you are referred to us in an emergency and will not be able to pay for your visit, please ask to speak with our billing office at the time of your appointment. If you obtain Medi-Cal coverage with retroactive coverage, you are responsible for notifying the billing office to bill any now covered services. We will refund any amount that you previously paid when we receive payment from Medi-Cal.

**Deposits and Credit Balances-** Deposits paid will be applied to the most recent date of service. Payments will be applied to the oldest date of service. Credits are applied to any outstanding balance. If you are in an active treatment plan, credits may be applied to future balances due. Any remaining credit balance after your treatment plan is complete will be refunded to you. Credit balances on your account may also be applied to outstanding balances at our surgery center, the Northern California Advanced Surgery Center, and vice versa.

**Auto Payment Collect Program-** We encourage you to enroll in our Auto Payment Collect Program to cover your patient balance. Enrolling in this program places your credit card on file and we will not collect non-drug related funds at time of service. We will charge your credit card after the insurance company has processed your claim and determined what your patient portion is.

**Credit Check-** We may run a credit check as part of our collection process.

*For Office Use Only:* MRN #: \_\_\_\_\_

**Past Due Accounts-** If your account becomes past due and/or you are unable to fulfill any payment plan agreement, please contact our billing office to discuss it. If your account is sent to collections, we will add 30% to your outstanding balance due to cover the collection fee unless prohibited by your insurance carrier.

**Civil Code Section 1785.27 Notice**

In the event you end up owing medical debt under our Insurance Authorization and Assignment and Financial Policies Agreement: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**I have read and acknowledge the above policies**

**Signature of Responsible Party**  
\_\_\_\_\_

**Date**  
\_\_\_\_\_

**Printed Name of Responsible Party**  
\_\_\_\_\_

**Patient Name if Other than Responsible Party**

---

***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgement refused

Efforts to obtain: \_\_\_\_\_

Reason for Refusal: \_\_\_\_\_