PATIENT REGISTRATION (please print)

Patient's Full Name _____ Sex: ☐ Male ☐ Female

Race (Please check) ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Other _____ ☐ Decline

Ethnicity (Please check) ☐ Non-Hispanic ☐ Hispanic ☐ Decline

Patient's Social Security # _____ Date of Birth_____ Age_____

Patient's Address: Street_____

City _____ State_____ Zip_____

For phone numbers and e-mail address, please do not include information for contacts to which you do not wish to have messages left or sent.

Home	
Mobile	
Work	
Other	
Email	

- I understand that Retina Centers of Alabama will use the contact information above for business purposes that may include but are not limited to the following: Appointment Reminders, Missed Appointment Follow-Up, Emergency, Appointment Rescheduling, Financial and other related calls.
- I give my permission for information and messages to be left or sent to the above contacts.
- I understand that if this contact information changes, it is my responsibility to contact Retina Centers of Alabama to have the changes made.

X Patient's Signature:_____ Date:_____

Primary Care Doctor _____ Referring Doctor _____

Financial Responsibility: ☐ Patient ☐ Other_____

Employer's Address: _____

Patient's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse Name_____

Person we may contact in case of an emergency: Name _____ Relationship _____

Primary Phone # (_____)_____ Secondary Phone # (_____)_____

We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

Primary Insurance: **Insurance Company** _____

Subscriber's ID #_____ Subscriber's Group #_____

Subscriber ___Self ___Other, Name of Subscriber _____ Subscriber's Sex ☐ Male ☐ Female

Subscriber's Date of Birth _____ Subscriber's Social Security #_____

Patient's Relationship to Subscriber: ☐ Spouse ☐ Parent ☐ Child ☐ Guardian ☐ Other, Specify _____

Subscriber's Empoyer _____

Secondary Insurance: **Insurance Company** _____

Subscriber's ID #_____ Subscriber's Group #_____

Subscriber ___Self ___Other, Name of Subscriber _____ Subscriber's Sex ☐ Male ☐ Female

Subscriber's Date of Birth _____ Subscriber's Social Security #_____

Patient's Relationship to Subscriber: ☐ Spouse ☐ Parent ☐ Child ☐ Guardian ☐ Other, Specify _____

Subscriber's Empoyer _____

Other Insurance: ☐ Yes ☐ No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Retina Centers of Alabama (RCA) and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RCA physician in his or her medical judgment and such medical care, examination and medical treatment as is reasonable incident thereto. I hereby authorize direct payment to RCA of all medical insurance benefits (including without limitation Medicare and Medicaid benefits and commercial insurance benefits) to which the Patient is entitled in consideration of services to be rendered by RCA to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to RCA for charges not covered by this agreement, and I hereby guarantee payment to RCA on demand for all such charges. I hereby agree to pay all costs associated with collection, attorney's fees and any other miscellaneous charges incurred by RCA in the course of collecting unpaid balances on my account.

X Patient's Signature:_____ **Date:**_____

Please check one: ☐ Patient ☐ Authorized Representative ☐ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RCA to furnish, to extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RCA to the Patient. I also hereby authorize RCA to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

X Patient's Signature:_____ **Date:**_____

Please check one: ☐ Patient ☐ Authorized Representative ☐ Parent or Guardian of Minor

MEDICARE BENEFICIARY'S LIFETIME PAYMENT AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Maynor and Mitchell Eye Center (Retina Centers of Alabama) for any services furnished to me by RCA. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service you provide for this beneficiary during his/her lifetime, unless revoked.

_____ X_____ _____

(Name of Beneficiary) (Beneficiary or his/her representative's signature) (Date)

HIPAA AUTHORIZATION:

I give my permission for the providers of Retina Centers of Alabama to release ANY information about my medical condition, prescriptions, samples, forms, medical records and financial account to:

Name:_____

Name:_____

Name:_____

The above-mentioned person(s) will be required to provide photo ID when picking up requested items.

Patient's Name_____ Date of Birth_____

X Patient's Signature:_____ **Date:**_____

Please check one: ___Patient ___Authorized Representative ___Parent or Guardian of Minor

ADDENDUM TO NOTICE OF PRIVACY PRACTICES:

The physicians and staff at Retina Centers of Alabama understand that that your medical information is personal and we are committed to protecting medical information about you. As we work to protect your personal health information (PHI), we also strive to provide you with the best medical care possible. Congress, along with Federal and State regulators have significantly increased their focus on the provision of quality health care through the creation of data reporting programs. There will be instances where your PHI may be communicated, transmitted and/or reported to other physicians and to the government in order to meet, and comply with, these regulations.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
(you may refuse to sign this acknowledgement)

I,_____, acknowledge that I have received a copy of the Notice of Privacy Practices

X Patient's Signature:_____ **Date:**_____

Please check one: ☐ Patient ☐ Authorized Representative ☐ Parent or Guardian of Minor

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For office use only

Retina Centers of Alabama attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ Emergency situation prevented us from obtaining acknowledgment

☐ Other_____

Staff Signature: _____

Printed Name: _____

Date: _____

Retina Centers of Alabama

- Please bring your insurance cards to every visit.
- Due to Federal regulations, all patients will be required to present a photo I.D. upon request.

Appointments

- Patients will be assigned a primary retina specialist within Retina Centers of Alabama (RCA) who will provide the majority of their care. If an emergency/urgent visit is needed at a time when your primary provider is not available, you may be scheduled to see another provider within the practice.
- Please be advised that your physician is not available for telephone consultations. If you have questions or problems that need to be discussed, this is best handled by scheduling an office visit.
- Our office requires a 24-hour advance notice for the cancellation or rescheduling of an appointment. We also understand that occasionally emergencies may arise beyond your control that will require an appointment cancellation on a short notice. We will try our best to accommodate you and re-schedule your appointment at a time convenient for you. However, repeated failure to keep your scheduled appointment, or failure to show for an appointment without notice may result in a "no-show" fee being assessed. In some situations, we may be forced to have your medical care transferred elsewhere.
- To cancel or reschedule an appointment, please call (256) 536-0505.
- A demographic/insurance information update is required every year. Please have your insurance information readily available at check in to allow us to process your information update in a timely manner.
- If you are more than 15 minutes late to your appointment, you may be required to reschedule your appointment.

Emergency Situations / Phone Calls

- If you have a need to communicate with our doctors after hours, please call the main number to Retina Centers of Alabama (256-536-0505). The answering service will then contact the physician or technician on call to assist you.
- Regular phone calls will be returned during the course of the day as the schedule allows. It is not necessary to make repeat phone calls to the office during the course of a day. Please allow some time for a return call.

Prescriptions

- Please ask for refills of prescription medications when you come into the office for a routine visit.
- When you call for a refill, please make sure to call for all medications that need to be refilled within the next thirty days.
- You may also request prescription refills directly from your pharmacist. The pharmacist will then use our prescription refill line to address your medication needs.
- Plan on a 72-hour turn-around time for phone prescription refills. Call the pharmacy to verify that the medication is ready for pick-up.

Test Results

- Whenever possible you will receive a phone call from a technician and/or physician regarding your test results. If you do not receive a call within a week of the testing being performed, please contact our office at (256) 536-0505.

Referrals/Prior Authorizations

- If your visit requires a referral and/or authorization, it is your responsibility to obtain the necessary documentation prior to your scheduled appointment. Your appointment may be delayed or rescheduled to allow for you to obtain the necessary referral or prior authorization documents.

Medical Records Request

- Please allow 7-10 business days to complete requests for medical records. You must sign a release form in order for your records request to be processed. There is a charge for medical records, based on statutory rates as set forth by the State of Alabama. You may call in advance to obtain the exact quote of the charge amount.

Billing & Payment

- Payment of co-pays is expected at the time of service.
- If you have any questions regarding your account balance, please call (256) 536-0505.
- As a courtesy to our patients, we bill insurance on your behalf. Once insurance has processed your claim, any uncovered amount will become your responsibility and will be applied to your account balance.
- You are responsible for obtaining and confirming any pre-approval or prior authorization required by your insurance company. If unpaid charges are accrued due to not having a pre-approval or prior authorization in place, these charges will be your responsibility.
- At Retina Centers of Alabama we understand that there may be instances where patients are unable to pay their balances in full. In these situations, we can work with you to set up an equitable payment plan. We are able to offer payment plans through Care Credit, and other options, which may allow for patients to pay off their balances over time. Please ask to speak to someone in our billing department if you would like to set up a payment plan.
- Please note, recurrent failure to pay your bill may result in your account being sent to a collection agent. The collection agent will add collection fees to your unpaid balance.
- Whenever possible, refunds are issued within thirty days of receipt of payment at Retina Centers of Alabama. If you aware of an account credit, please allow thirty days before contacting us. To contact us regarding a refund, please call (256) 536-0505.

Forms

- If you have a disability, DMV, FMLA or work/physical forms that need completion, we are happy to assist you in completing these forms. Please be advised that there is a charge for form completion, ranging from $15 to $75, based on the complexity of the form and the number of pages to be filled out. There is no charge for legal blindness certification letters.

By signing on the line below, I acknowledge that I have been provided access to the Patient Information Sheet of Retina Centers of Alabama

X Patient Signature:_____ Date:_____