RETINA AND UVEITIS CENTER

# New Patient Registration Form

Account Number: _____

## Patient Demographic Information

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Name | | Maiden Name |
| Street Address | | State | City | Zip Code |
| Home Phone | Mobile Phone | Email Address | | |
| Social Security Number | Sex ☐Male ☐Female | Date of Birth | Age | Driver's License Number |
| Marital Status ☐Single ☐Married ☐Divorced ☐Widowed | | Spouses Name (If Applicable) | | |
| Race (Check One) ☐White ☐Black ☐Asian ☐Other _____ | | Is patient residing in a Skilled Nursing Facility/Rehabilitation Center? ☐Yes ☐No | | If yes, Name of Facility |
| Employment Status | | | | City / Phone Number |
| **Primary Care Physician's Name** | | **Primary Care Physician's Phone Number** | | |
| **Primary Care Physician's Address** | | **State** | **City** | **Zip Code** |

**Complete this section if Patient is a minor or has a Legal Guardian.**

## Responsible Party

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | | | MI |
| Street Address | | State | City | **Zip Code** |
| Cell Phone Number | Home Phone Number | Work Phone Number | | Email Address |
| Social Security Number | | Sex ☐Male ☐Female | | |
| Marital Status ☐Single ☐Married ☐Divorced ☐Widowed | | Date of Birth | | |
| Primary Care Physician's Name | | | | |
| Primary Care Physician's Address | | State | City | Zip Code |

## Insurance and Subscriber Information

| | | | |
|---|---|---|---|
| **Primary** Insurance Company / Effective Date | | **Secondary** Insurance Company / Effective Date | |
| Claims Mailing Address (Street or Box) | | | |
| State / City / Zip Code | | State / City / Zip Code | |
| Policy ID Number | Group ID Number | Policy ID Number | Group ID Number |
| Subscriber Name (Policy Holder) | Date of Birth | Subscriber Name (Policy Holder) | Date of Birth |
| Subscriber Social Security Number | Relationship to Patient | Subscriber Social Security Number | Relationship to Patient |
| Subscriber Employer | Work Phone Number | Subscriber Employer | Work Phone Number |

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## CONSENT TO TREAT

I hereby consent to allow employees and agents of Paragon Retina, PLLC including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and treatment that they deem necessary for my health and well-being. I acknowledge that neither my physician nor any supporting staff have made any guarantee or promise as to the results of any treatment received by Paragon Retina, PLLC. I understand that by not signing this consent, I will not be provided medical care except in the case of an emergency. The duration of this consent is indefinite and continues until revoked in writing.

_____

**Patient Name (Please PRINT)**

_____ _____

**Signature** **Date**

***Complete this section ONLY if patient is a minor or requires a Legal Guardian***

I consent to evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

**Signature of Parent or Legal Guardian** **Date**

## INFORMATION REGARDING DILATING 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. The actual effects of dilation on individuals are impossible to determine, which is why we recommend all patients to take appropriate precautions. Due to light sensitivity and blurred vision, driving may be difficult immediately after an examination, it is recommended that you make alternative travel arrangements. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. Understanding that the eye drops are necessary to diagnose my condition, my signature below additionally authorizes Retina and Uveitis Center and any designated care giver to administer dilating eye drops.

_____

**Patient Name (Please PRINT)**

_____ _____

**Signature of Patient, Parent, or Legal Guardian** **Date**

## FINANCIAL POLICY

I hereby authorize Paragon Retina, PLLC to apply for benefits on my behalf and for payment of medical benefits directly to Paragon Retina, PLLC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to Paragon Retina, PLLC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Paragon Retina, PLLC. I further understand that should my account balance become delinquent and sent to a third-party collector, I agree to pay an additional 30% of the balance or $50, whichever is greater. I also understand that a returned check fee of $35 will be assessed if the check is returned by my bank.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

_____

**Patient Name (Please PRINT)**

_____ _____

**Signature of Patient, Parent, or Legal Guardian** **Date**

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## PREFERRED METHOD OF COMMUNICATION

☐ **Yes**, I want Paragon Retina, PLLC to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my **medical conditions and/or appointment information** is indicated below:

☐ Home Phone ☐ Cell Phone ☐ Work Phone
☐ Mailed Letter ☐ Guardian ☐ Email

If the above method of communication is done by **phone**, please do one of the following (**please check ONE**):

☐ Leave a message with detailed information
☐ Leave a message with a call-back number only.

If the above method of communication is by email, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

**Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.**

## PREFERRED CONTACTS

In accordance with HIPPA privacy standards, it is important to us to keep patient's Protected Health Information (PHI) private. We will not disclose information related to the patient's Billing Account or Medical Conditions to anyone other than the patient or legal guardian (Power of Attorney provided). If you would like to add additional contacts, other than the patient or legal guardian, that Paragon Retina, LLC is allowed to disclose this type of information to, please complete the fields below and select the level of disclosure for each person based on discretion. If End Date is left blank, the authorization is indefinite unless otherwise revoked in writing.

_____ _____ _____ _____
Contact Name | Relationship to Patient | Contact Phone Number | End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

_____ _____ _____ _____
Contact Name | Relationship to Patient | Contact Phone Number | End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

## NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Paragon Retina, PLLC is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice. The Privacy Notice describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services. By entering your name and date below, you acknowledge the receipt of a Paragon Retina's Notice of Privacy Practices.

_____
**Patient Name (Please PRINT)**

_____ _____
**Signature of Patient, Parent, or Legal Guardian** **Date**

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT OF RECEIPT CONTINUED

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify):

_____

_____

***This Acknowledgement Form will become part of your permanent medical record.***