Retina Macula Specialists

PATIENT REGISTRATION DATA FORM

Today's Date _____

PERSONAL INFORMATION

Name _____

Address _____

City, St, Zip _____

Birth Date _____ Age _____

Social Security # _____

Home Phone _____

Cell Phone/Other Phone _____

Driver's License # _____

Driver's License State _____

Occupation _____

Employer _____

Address _____

City, St, Zip _____

Work Phone _____

Circle: Married Single Divorced Other

If Married, spouse name:

_____

Spouse Phone: _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Phone Number _____

_____

Signature of Patient or legally authorized Individual

Referred By _____

Primary Physician _____

Primary Physician Ph # _____

INSURANCE INFORMATION

Insurance Carrier _____

Address _____

_____

Subscriber _____

Subscriber ID# _____

Group# _____

If policy holder is someone other than you, please provide:

Name _____

Social Security # _____

Date of Birth _____

Employer _____

SECONDARY INSURANCE

Insurance Carrier _____

Address _____

_____

Subscriber _____

Subscriber ID# _____

Group# _____

_____

Date

RETINA Macula SPECIALISTS

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

TREATMENT

Retina Macula Specialists, PLLC and any physician examining and/or treating you to release to any subsequent treating physician any medical information and/or records concerning diagnosis and treatment.

PAYMENT

Medical records and/or information will be shared with third party payers, such as insurance companies or the Social Security Administration or its intermediaries or carriers when requested for use in connection with determining a claim for payment.

APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with appointment reminders, including but not limited to voicemail messages, postcards or letters.

HEALTHCARE OPERATIONS

Medical record information may be used in performing the following activities:

- Quality Improvement
- Reviewing competence or qualifications of healthcare professionals
- Underwriting, premium rating and other insurance activities
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development
- General administrative duties including, but not limited to:
    - Compliance management
    - Customer service
    - Resolution of internal grievances

YOUR RIGHTS

You have the right to request restrictions regarding usage / disclosure of information
You have the right to receive confidential communications
You have the right to inspect and copy protected health information
You have the right to amend incorrect or incomplete protected health information
You have the right to receive an accounting of disclosures
You have the right to receive a paper copy of this Notice

Additional HIPAA compliance notification information is available. If you have questions about this notice, please contact:

Privacy Officer, c/o Medical records, Retina Macula Specialists, PLLC, 720 W. Oak Street, Suite 301, Kissimmee, FL 34741, (407)931-1510.

PAYMENT AUTHORIZATION

PAYMENT AGREEMENT AND AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment by my insurance company to Dr. Jaime Membreno, M.D. directly. I understand that any monies received over and above my indebtedness will be refunded to me when my bill is paid in full and that I am financially responsible for charges not covered under this authorization.

I understand that I am legally responsible for the payment of charges for services. Furthermore, I understand that payment for charges not covered contractually by insurance are due at the time of service.

I have read, understand and agree to Retina Macula Specialists, PLLC Financial Policy. I permit a copy of these authorizations and assignments to be used in place of this original.

_____ _____

Signature of Patient or legally authorized individual Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any of my medical records which may be requested by my insurance company for the purpose of processing an insurance claim. A copy of this authorization may be used in lieu of the original. I further authorize release to any subsequent treating physician any medical information and/or records concerning diagnosis and treatment.

_____ _____

Signature of Patient or legally authorized individual Date

Per HIPPA guidelines, please list any family members or significant others that you allow Retina Macula Specialists, PLLC to release information to:

Name _____ Relationship _____

Name _____ Relationship _____

Please note: it is your responsibility to notify us of any changes to this list.

Retina Macula Specialists

LIFETIME MEDICARE B / INSURANCE SIGNATURE AUTHORIZATION

I understand that Dr. Jaime Membreno may provide services and/or devices that he deems necessary for my care / treatment which my insurance may not cover. Dr. Jaime Membreno's decision is a professional one made in my best interest and is not dictated by any government agency. To this end, I hereby authorize and accept full responsibility for the charges associated with such services and / or devices.

I authorize Retina Macula Specialists, PLLC to use this signature as a release to the Social Security Administration, its intermediaries, carriers, and/or to the billing agent of this physician or supplier, of any information needed for this or a related Medicare / Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit either to myself or the party who accepted assignment. I may revoke this authorization by notifying Retina Macula Specialists, PLLC in writing.

I acknowledge receipt of Retina Macula Specialist's Notice of Privacy Practices as instructed by the Health Insurance Portability and Accountability Act **(HIPAA).**

_____ _____

Signature of Patient or legally authorized individual Date

Retina Macula Specialists

INFORMATION REGARDING DILATING EYE DROPS

Dilating eye 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's best if you make arrangements not to drive yourself.

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.

I hereby authorize Dr. Jaime Membreno , MD 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.

_____ _____

Patient(or person authorized to sign for patient) Date

_____ _____

Witness Date