ep eye physicians

Patient Registration

NP v.2018

Patient Information

Last Name:________________ First Name:________________ M.I.:______

Address:________________________________ Apt #: __________

City:________________________ State:____________ Zip:__________

Home #:______________ Cell #:______________ Work #: __________

Date of Birth: __________ Last 4 SS#: ______ Marital Status: ☐**S** ☐**M** ☐**D** ☐**W** **Gender:** ☐**M** ☐**F**

Occupation:____________________ Email:______________________

Race:______________ Ethnicity:______________ Language:__________

How were you referred to our office?: ☐Referring MD ☐PCP ☐Online ☐Patient/Other: __________

Medical Information

Emergency Contact:________________ **Pharmacy Contact:** ______________

Phone:________________________ Address:________________________

Relationship:__________________ Phone:__________________________

Referring MD:________________ **Primary (PCP) MD:** ______________

Phone:________________________ Phone:__________________________

Address:______________________ Address:________________________

City:__________ State:______ Zip:______ City:__________ State:______ Zip: ______

Insurance Information

Are you currently employed? **YES** **NO**

Do you/your spouse have employee health insurance with an employer who employs 20 or more? Y / N

Primary Insurance:________________ **Secondary Insurance:** ______________

Policy Number:__________________ Policy Number: __________________

Group #:________________________ Group #: ________________________

Policy Holder Name:______________ Policy Holder Name: ______________

Policy Holder DOB:_____/_____/________ Policy Holder DOB:_____/_____/________

Relationship to Policy Holder:__________ Relationship to Policy Holder: __________

Authorization and Release

I hereby authorize my physician to furnish information to insurance carriers concerning my illness, accident and/or treatment. I hereby assign the physician all payments for medical service rendered to myself or to my dependents. I understand I am financially responsible for any charge incurred whether or not paid for by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

______________________________ ______________________

Signature of Patient, Parent or Legal Guardian Date

Account Number:____________

Consent to Treat

I hereby authorize employees and agents of Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY including physicians, technicians, and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

______________________________________ ________________

Patient Name **Date**

____

Signature of Patient, Parent, or Legal Guardian

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

I consent for___________________________to authorize 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 Patient, Parent, or Legal Guardian **Date**

Account Number:____________

Financial Responsibility

I hereby authorize Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY to apply for benefits on my behalf and for payment of medical benefits directly to Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY. 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 Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY. 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 **Date**

____
Signature of Patient, Parent, or Legal Guardian

Account Number:____________

Notice of Privacy Practices and Acknowledgement of Receipt

Patient Name:________________________________ **Date:____/____/____**

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.

Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY 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, which 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.

On____/____/____I,____________________________, received a copy of this office’s Notice of Privacy Practices.

____________________________________ ________________

Patient Name **Date**

____

Signature

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
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

Employee Initials: ________

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

Account Number:____________

Clinical Summary Request

I hereby request to receive a Clinical Summary of my visit. I understand that this will be provided to me after my appointment is complete, either at the time of departure or via the portal. I further acknowledge that by signing this I am entitled to receive a Clinical Summary following each visit hereafter:

____________________________________ __________________

Patient Name **Date**

____

Signature of Patient, Parent, or Legal Guardian

Patient Preferences Regarding Communication of PHI (Protected Health Information)

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.
If you would like to add additional contacts, other than the patient or legal guardian, that VRMNY is allowed to disclose this type of information t**o**, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient Number	Contact Phone	End Date
_____________	_________________	__________________	_________

☐ **Billing Account Information** ☐**Medical Condition Information**

Additional Notes:____

Account Number:____________

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

MEDICARE #: ____________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
Please sign and print your name exactly as it appears on your Medicare card.

_____________________________________ __________________
Patient Name **Date**

____
Signature of Patient, Parent, or Legal Guardian