
## PATIENT INFORMATION

**Today's Date:**

**Legal** First Name _____ Last Name _____ MI __
Date of Birth _____ Age____ Marital Status ____ SEX M or F
SS# _____ Email _____
Address _____ City_____ State ____ Zip _____
Home # _____Cell # _____ Work # _____
Employer Name _____ City _____ State _____

## INSURANCE INFORMATION

Primary Insurance Carrier _____ Policy#_____ Group#_____
**Policy Holder's** First Name _____ Last Name_____ MI___
**Policy Holder's** DOB _____ SS# _____
Patient's Relationship to Insured: Self / Spouse / Child / Other (circle one)

Secondary Carrier _____ Policy#_____ Group #_____
**Policy Holder's** First Name _____ Last Name_____ MI__
**Policy Holder's** DOB _____ SS# _____
Patient's Relationship to Insured: Self / Spouse / Child / Other (circle one)

## EMERGENCY CONTACT

Name _____ Relationship_____ Phone _____


**TODAY'S DATE _____**
**PATIENT NAME: _____**
**DOB: _____**

**FINANCIAL/INSURANCE POLICY**

We have contracted with many insurance carriers and managed care networks to be providers on their plans. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are anxious to help you receive your maximum benefits allowed. In order to achieve this goal, we ask for your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of a valid insurance, you will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurance companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at the time of service.

We must emphasize that filing of claims is a courtesy we extent to all our patients. All charges are your responsibility from the date of services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

**PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW**: I hereby authorize STAR RETINA, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that STAR RETINA will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature _____ Date _____


**TODAY'S DATE _____**
**PATIENT NAME: _____**
**DOB: _____**

**CONSENT FOR USE AND DISCLOSURE OF INFORMATION**

I have reviewed the NOTICE OF PRIVACY PRACTICES of STAR RETINA. I also consent to the use or disclosure of my protected health information for the following purposes:

**A) TREATMENT**

It will be necessary to share protected health information with all members of the treatment team for restatement purposes. This can included employees in this office, as well as other providers.

**B) PAYMENT**

Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for the billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

**C) HEALTHCARE OPERATIONS**

Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws. I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

**D) DISCLOSURE OF MEDICAL INFORMATION**

***Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (example: your spouse or a parent):***

_____ _____

_____ _____

_____ _____

**Patient Name (Printed)** **Date**

**Patient Signature**


**TODAY'S DATE** _____
**PATIENT NAME:** _____
**DOB:** _____

## PATIENT REFUND POLICY

STAR RETINA strives to collect the accurate amount owed from patients for co-pays, deductibles, and co-insurance.

However, on some occasions the patient will be due a refund. In the instance of a required refund, the following policies shall apply:

- Refunds are processed for payment within 30 days of notification from the insurance provider, patient, or explanation of benefits that a refund is due to the patient.
- If the patient paid for services with a debit or credit card, we will process the refund back to that specific card. We will NOT issue checks for credit or debit card refunds.
- If the payment was made with a check or cash, we will provide the refund in the form of a paper check and mail to the patient's last known address.

I (print name) _____ have read the STAR RETINA refund policy and understand how refunds are processed.

_____ _____
Patient or Guardian Signature Date

**TODAY'S DATE** _____
**PATIENT NAME:** _____
**DOB:** _____

## PATIENT HISTORY QUESTIONNAIRE

**Referred by**:

Dr._____ OR Internet/Google OR Friend/Family:_____

What is the reason for your visit today?

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**History of EYE SURGERY?**

☐None

| | | | |
|---|---|---|---|
| ☐Cataract Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐Cornea Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐Glaucoma Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐Strabismus Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐LASIK, PRK, RK | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐Retinal Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |
| ☐Vitreous Surgery | RIGHT EYE | LEFT EYE | BOTH EYES |

☐Other: _____

**HISTORY OF EYE DISEASES OR PROBLEM?** ☐ NONE
If YES, pleas list (Macular Degeneration, Glaucoma, Iritis, Dry Eye Syndrome)

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**List Current eye drops:** ☐ NONE

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**List any Drug Allergies (along with reaction)**: ☐ NONE

_____


**Patient Pharmacy** _____
**Pharmacy Street/Intersection:** _____**City:**_____

**Primary Care Provider:** _____**Phone:**_____

**Patient Medical History**

☐Diabetes ☐Cancer ☐Heart Attack ☐Hypertension ☐Stroke

☐Kidney Disease ☐Dialysis ☐Asthma ☐Arthritis ☐HIV/AIDS

☐None ☐ Other: _____

**Major Surgeries within the last 10 years**: ☐None

If yes please list: _____

**Do you wear Contact Lenses?** ☐No ☐ Yes

**Family History of eye disease?** ☐ No ☐Yes

☐Glaucoma Family Member: _____

☐Macular Degeneration Family Member: _____

☐Retinal Detachment Family Member: _____

☐Uveitis (Eye Inflammation) Family Member: _____

☐Retinitis Pigmentosa Family Member: _____

**Social History:** (circle your answer)

Tobacco: NEVER / YES / PREVIOUS
Alcohol: NEVER / YES / PREVIOUS
Recreational Drugs: NEVER / YES / PREVIOUS

STAR RETINA

**Please list ALL medications you are currently taking**:

_____

_____

_____

_____

☐ I am not currently taking any medication

**Review of Current EYE Symptoms**

**☐Pain**

**☐Blurry Vision**

**☐Flashes of Light**

**☐Floaters**

**☐Loss of vision**

**☐Double Vision**

**☐None of the Above apply to me today**

**☐Other (please list below)**

Please explain if yes: Which eye, how long have you had the symptoms?

_____

_____

_____

_____

# STAR RETINA – NOTICE OF PRIVACY PRACTICES

## Protecting Your Privacy

Protecting you privacy and medical information is at the core of our practice. We recognize our obligation to keep your information (both written and digital) secure and confidential. At STAR RETINA, your privacy is one of our highest priorities.

## Keeping Your Information

Our employees access information about you only when necessary to provide treatment, determine eligibility, obtain authorization, process claims and otherwise meet your needs. We may access your information when considering a request from you, when exercising our right under the law, or any agreement with you. We safeguard information during all business practices accordingly to established security standards and procedures, and we continually assess technology for protecting information. **Our employees are trained to understand and comply with these information principles**.

## Working to Meet Your Needs Through Information

In the course of doing business, we collect and use various information, such as name, address and claims information. We use this information to provide service, process claims and provide health information that might be of interest to you. Keeping your health information accurate and up-to-date is very important. If you believe health information we have about you is incomplete, inaccurate or not current, please inform us immediately. We take appropriate action to correct any erroneous information promptly through standard set of practices and procedures.

## How and Why Information is Shared

We share information within our practice to deliver you health care services, related information and education programs specified to your care. To help us offer you our services, we may share information with companies that work for us, such as claims processing, mailing companies and companies that deliver

health information directly to you. These companies act on our behalf and are obligated contractually to keep this information confidential. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that those receiving the data will not, without your permission, release it further. If we receive a subpoena or similar legal process demanding release of your information, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties including government agencies. **STAR RETINA does not share any customer information with third-party marketers who offer their products and services to our patients.**

**Count On Our Commitment To Your Privacy**

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether its our office, the phone or the internet.

***You have the right to obtain a paper copy of this notice from us, upon request.***

## Patient Acknowledgement of Receipt of Privacy Practices

I (print name) _____ acknowledge that I have read and understand the STAR RETINA Privacy Practices. I understand this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician practice provides this notice to me.

Patient Signature: _____

Date: _____