Patient Registration

Retina associates

❒ New ❒ Merrillville ❒ Munster

Acct: _____ ❒ Update ❒ Michigan City ❒ Valparaiso

PLEASE PRINT CLEARLY

Date _____ Doctor: ❒ Amin ❒ Chasan ❒ Eadie ❒ Lipman ❒ Pelzek ❒ Vyas

Patient Name _____ Age _____ ❒ Male ❒ Female

Address _____ City/State/Zip _____

Home Phone _____ Alternate # or Cell #_____

Date of Birth _____/_____/_____ Employer _____

Marital Status: PLEASE CHECK ONE ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Patient Referred By _____ Address/City/Phone _____

Family Physician _____ Address/City/Phone _____

PRIMARY INSURANCE COMPANY_____

Policyholder's Name _____ Policy #_____

Relationship to Patient _____ Date of Birth _____

SECONDARY INSURANCE COMPANY_____

Policyholder's Name _____ Policy #_____

Relationship to Patient _____ Date of Birth _____

NURSING HOME RESIDENT? ❒ YES ❒ NO STATUS? ❒ IN-PATIENT ❒ OUT-PATIENT

Facility Name _____ City _____

If Patient is a minor, who is responsible? _____

Relationship to patient _____ Phone # _____

If accident, were you injured at: ❒ Work ❒ Auto ❒ Other _____

What happened? _____ Date of Accident _____

Person to contact _____ Phone # _____

Retina associates

Comprehensive diagnostic and surgical care of the retina, macula and vitreous

Financial Responsibility Statement/Release of Information Authorization

MEDICARE

I request that payment of authorization Medicare benefits be made to Retina Associates on my behalf for any services furnished me by their physician. I authorize and holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Medicare Supplement

I request that payment of authorization Medigap benefits be made on my behalf to Retina Associates for any services furnished me by their physicians. I authorize any holder of medical Information about me to release to my insurance any medical information needed to determine these benefits or the benefits payable for related services.

Private Insurance

I authorize Retina Associates to furnish information to insurance carriers concerning the illness or medical treatment of my dependent or myself; and I hereby assign to the provider(s) all insurance payment for medical services rendered to myself/or my dependent. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

HMO/PPO/POS

I understand that I am responsible for obtaining a referral, referral number, authorization number and/or precertification number for all visits/services performed by Retina Associates, and its physicians. If my HMO/PPO managed care plan denies payment due to lack of required referrals, referral numbers, authorization numbers, and/or precertification numbers, I agree to be personally and fully responsible for payment.

For the safety of our patients and our staff, Retina Associates has a zero-tolerance policy for any behavior that is deemed threatening, harassing or intimidating. Retina Associates is committed to providing excellent patient care in a professional and respectful environment.

Patient Initials _____

Signature of Patient or Responsible Party: _____

Date: _____