SUMMIT EYE
PARTNERS

Erin B. Lally, M.D.
Comprehensive Ophthalmology

4370 Alpine Road, Suite 200, Portola Valley, CA 94028
P: 650.325.3937 F: 650.231.5007 www.summiteyepartners.com

PATIENT REGISTRATION

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address: _____

Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____

Gender M F

Employer_____Occupation_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number(s)_____Relationship_____

Please provide a copy of all insurance cards to the front desk, or we may not be able to bill your insurance.

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

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Patient Name._____ Today's Date_____
Last First Middle

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

PHARMACY INFORMATION:

_____ _____ _____ (___)_____
Preferred Pharmacy Street Address City Phone #

PHYSICIAN INFORMATION:

_____ _____ (___)_____
Primary Care Doctor City Phone #

_____ _____ (___)_____
Regular Eye Doctor City Phone #

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Retinal Diagnostic Center to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I understand that I am financially responsible for all copays, coinsurances and deductibles. I am aware there may be additional collection and/or attorney's fees if my account is referred 2/8collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

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Patient Name._____ Today's Date_____
Last First Middle

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Retinal Diagnostic Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access:

(e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity: **Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____
Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____
Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Retinal Diagnostic Center.

_____
Signature of the Patient or Patient Representative

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PATIENT MEDICAL HISTORY INFORMATION FORM

Patient Name: _____ **Date:** _____

Please check appropriate box if you have history of:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Abnormal Bleeding
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ Allergies
- ☐ Prematurity at birth
- ☐ Emphysema
- ☐ Migraine Headaches
- ☐ Smoking
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High Myopia
- ☐ Lazy Eye, Stabismus/Amblyopia
- ☐ Eye Surgery
- ☐ Other Eye Problems: _____

_____

In case of emergency, please call: _____

Phone Number: _____ Relationship to Patient: _____

Family Eye Problems:

- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Retinitis Pigmentosa
- ☐ High Myopia
- ☐ Other: _____

Are you allergic to any medication? ☐ Yes ☐ No

If yes, what medications: _____

_____

Please list all current medications: _____

_____

_____

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FINANCIAL POLICY

- **Payment Due**: I understand that payment is due when service is rendered.
- **Co-pay, Co-insurance and Deductibles.** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.
- **Insurance Coverage**: I acknowledge that the insurance cards I have presented are current and accurate.
- **Non-covered Services**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges**: I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deems them payable or not and that I am obligated to pay for these services in full.
- **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Returned Checks & Past Due Accounts;** Returned checks will be subject to collection charges, penalties and interest.

  All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept postdated checks.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur addition charges (in addition to the surgeon's fees) from the surgery facility and anesthesiologist.
- **Authorizations**: Some insurance plan require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.

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State of California Patient Questionnaire

The California Health and Safety Code (Section 128737) requires that we collect the following information for the Office of Statewide Health Planning and Development. In compliance with this code, we ask that you please complete the following questionnaire.

Patient Name: _____ **Date:** _____

Gender: ☐ Male ☐ Female

Language: _____

Marital Status: _____

(Please circle One)

Ethnicity: African American - American Indian/Alaskan Native - Asian - Asian Indian - British -

Cambodian - Caucasian - Central American - Filipino - French - Hispanic or Latino - Korean - Pacific

Islander - Non Hispanic or Non Latino - Other: _____

Decline to State

Race: African American - American Indian/Alaskan Native - Caucasian - Hispanic Latino - Hawaiian or

Other Pacific Islander - Unknown - Other: _____

Decline to State

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers? □ Yes □ No Home Phone: _____

□ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No

If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? □ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Retinal Diagnostic Center to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**. I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed the HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____

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HIPAA ACKNOWLEDGEMENT & CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____