Retina Associates of Middle Georgia, P.C.

Registration Form

Patient Information

Last Name: _____ First Name: _____ M.I. _____

S.S #: _____ ____ Married ____ Single ____ Widow

Date of Birth: _____ Age: _____ ____ Male ____ Female Race:

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Patient Employed by: _____

Home Phone: (____) _____ Do you have VA Benefits? _____

Work Phone: (____) _____ Primary Insurance: _____

Cell Phone: (____) _____ Secondary Insurance: _____

Medical Doctor: _____ Referring Ophthalmologist: _____

Spouse/ Parent/ Guardian Information

Name: _____ Work Number: (____)_____

S.S #: _____ Employer: _____

DOB: _____ Work Address: _____

Authorizations

*****Please Present Insurance Cards To The Receptionist*****

- I hereby authorize and request the medical treatment necessary for the care of the above-named patient.
- I authorize the release of all medical records and appeals to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my records, if necessary.
- I acknowledge full financial responsibility for services rendered by Retina Associates of Middle Georgia PC.
- I understand payment is due at the time of the services unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for un-met deductibles and co-insurance fees.
- I further authorize and request that insurance payments be made directly to Retina Associates of Middle Georgia PC, for services rendered.

I have read and fully understand the above consent or treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Date Patient/ Parent or Guardian Signature Please Print Patient/ Parent Guardian Name

Retina Associates of Middle Georgia

160 Water Tower Court Macon, Georgia 31210

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

- **AUTHORIZATION TO RELEASE:**
  I HEREBY AUTHORIZE RETINA ASSOCIATES OF MIDDLE GEORGIA, MY ATTENDING PHYSICIAN, TO RELEASE OR DISCLOSE INFORMATION FROM MY MEDICAL RECORDS PERTAINING TO THE VISIT IN ACCORDANCE WITH THE POLICIES OF THIS OFFICE TO INSURANCE COMPANIES AND/OR OUTPATIENT BENEFIT PROGRAMS AS NEEDED TO PROCESS THIS CLAIM.
- **AUTHORIZATION TO PAY INSURANCE BENEFITS:**
  I HEREBY ASSIGN PAYMENT DIRECTLY TO THE ABOCE NAMED PROVIDER, BENEFITS WHERIN SPECIFIED AND OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE PHYSICIANS REGULAR CHAREGES FOR THIS VISIT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGERS NOT COVERED BY THIS AUTHORIZATION.
- **STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT:**
  I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS IS THE CORRECT INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIANS SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT CLAIM TO MEDICARE FOR PAYMENT TO ME.
- **MEDICAID PATIENT CERTIFICATION:**
  I CERTIFY THAT I AM A RECIPIENT OF THE MEDICAID TITLE XIX PROGRAM AND REQUEST THAT PAYMENTS OR AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION CONCERNING MEDICAL, INSURANCE, AND FINANCIAL RECORDS RELATING TO MY OUTPATIENT VISIT. I HEREBY CERITFY ALL INSURANCE SHALL BE ASSIGNED TO RETINA ASSOCIATES OF MIDDLE GEORGIA FOR SERVICES RENDERED.
- **CONSENT FOR TREATMENT:**
  THE UNDERSIGNED AUTHORIZES THE PHYSICIAN ASSIGNED TO FURNISH MEDICAL AND SURGICAL TREATMENT INCLUDING INTRAVENOUS SOLUTION, BLOOD TRANSFUSION, LOCAL ANESTHESIA, ADMINISTRATION OF ALL ANESTHETICS, THEIR PERFORMANCE OR ALL OPERATIONS, AND THOSE MEANS HE CONSIDERS NECESSARY AND PROPER IN THE TREATMENT OF THE PATIENT IDENTIFIED BELOW.
- **FINANCIAL AGREEMENT:**
  FOR SERVICES RENDERED TO THE PATIENT NAMED BELOW, I UNDERSIGNED AGREE TO PAY ALL PROFESSIONAL AND OUTPATIENT VISIT CHARGES NOT COVERED BY INSURANCE. I ALSO AGREE TO PAY REASONABLE ATTORNEY AND/OR COLLECTION FEES NECESSARY FOR THE COLLECTION OF PAYMENT.

DATE	SIGNATURE OF PATIENT (OR GUARDIAN)	SIGNATURE OF INSURED

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of Retina Associates of Middle Georgia's Privacy Practices

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous/Maiden Name: _____

I understand that the patient's health information is private and confidential. I understand that Retina Associates of Middle Georgia works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Retina Associates of Middle Georgia may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

Retina Associates of Middle Georgia, P.C. has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is attached to the Acknowledgement. I understand that I have the right to read the "Notice" before signing the Acknowledgement.

Retina Associates of Middle Georgia, P.C. may update this Acknowledgement and "Notice of Privacy Practices." If I ask, Retina Associates of Middle Georgia, P.C. will provide me with the most current "Notice of Privacy Practices."

Within this Notice of Privacy Practice is contained a complete description of my privacy/confidentiality rights. These include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative location.

Retina Associates of Middle Georgia, P.C. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgement, and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist Retina Associates of Middle Georgia by following these procedures if I choose to exercise any of my described rights in the "Notice of Privacy Practices."

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by another individual (Parent, legal guardian, personal representative, etc.)

I _____, give the following person(s) permission to receive information about my medical condition and any treatment that may be necessary.

Retina Associates of Middle Georgia

160 Water Tower Court Macon, Georgia 31210

PLEASE PROVIDE THE FOLLOWING INFORMATION AS NEEDED TO COMPLY WITH NEW INSURANCE PRESCRIBING GUIDELINES. YOUR PRESCRIPTIONS WILL NOW BE SENT ELECTRONICALLY TO YOUR PHARMACY THEREFORE YOU WILL NO LONGER RECEIVE A WRITTEN PRESCRIPTION.

PATIENT NAME: _____ **DOB:** _____

PATIENT ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

PHARMACY: _____

PHARMACY ADDRESS: _____

CITY: _____

Retina Associates of Middle Georgia

160 Water Tower Court Macon, Georgia 31210

MEDICATION LIST

PATIENT: _____

DOB: _____

MEDICATION:	**DOSAGE:**

Retina Associates of Middle Georgia

PATIENT INFORMATION

NAME: _____ (TECH USE ONLY) _____
FIRST MIDDLE LAST

DOB: _____ AGE: _____ MARITAL STATUS: S M W D

PATIENT EYE HISTORY

	PATIENT	WHICH EYE	FAMILY HISTORY
CATARACT	YES NO	RIGHT LEFT	YES NO
GLAUCOMA	YES NO	RIGHT LEFT	YES NO
TRAUMA/INJURY	YES NO	RIGHT LEFT	YES NO
RETINAL TEAR	YES NO	RIGHT LEFT	YES NO
RETINAL DETACHMENT	YES NO	RIGHT LEFT	YES NO
MACULAR DEGENERATION	YES NO	RIGHT LEFT	YES NO
DIABETIC EYE DISEASE	YES NO	RIGHT LEFT	YES NO

PATIENT MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	PATIENT	YEAR DIAGNOSED	FAMILY HISTORY
DIABETES	YES NO	_____	YES NO
HIGH BLOOD PRESSURE	YES NO	_____	YES NO
HEART ATTACK/ HEART DISEASE	YES NO	_____	YES NO
KIDNEY DISEASE/ STONES	YES NO	_____	YES NO
LIVER DISEASE/ HEPATITIS	YES NO	_____	YES NO
LUNG DISEASE	YES NO	_____	YES NO
STROKE/ NEUROLOGICAL	YES NO	_____	YES NO
CANCER	YES NO	_____	YES NO
HIV / AIDS	YES NO	_____	YES NO
ABNORMAL BLEEDING	YES NO	_____	YES NO
ARTHRITIS	YES NO	_____	YES NO
GASTROINTESTINAL PROBLEMS	YES NO	_____	YES NO

LIST ANY SURGERIES: _____

_____

DRUG ALLERGIES: _____

_____

CURRENT MEDICATIONS, STRENGTH AND DOSAGE (You May Use Page 8.) _____

_____

DO YOU OR HAVE YOU EVER USED TOBACCO? YES NO PACKS PER DAY: _____

DO YOU OR HAVE YOU EVER USED ALCOHOL? YES NO

DO YOU OR HAVE YOU EVER USED RECREATIONAL DRUGS? YES NO

(FOR WOMEN) ARE YOU PREGNANT? YES NO IF YES, DUE DATE? _____

DOCTORS USE ONLY

REFERRING PHYSICIAN _____
FAMILY PHYSICIAN _____
CHIEF COMPLAINT _____

CONSTITUTIONAL
CV
PULMONARY
GI.GU
RENAL
NEUROLOGICAL
HEMATOLOGICAL
ENDOCRINE

Retina Associates of Middle Georgia

160 Water Tower Court Macon, Georgia 31210

INFORMATION REGARDING DILATING EYE DROPS

Dilating 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 to have a driver.

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 Norman C. Nelson, Jr., M.D. / Steven D. Allee, M.D. / Arpan K. Bachhawat, M.D. 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