Retina CONSULTANTS of Seattle

PATIENT INFORMATION

NAME (LAST, FIRST, MI): _____ PREFERRED NAME: _____

ADDRESS: _____ PREFERRED PRONOUNS: THEY/THEM HE/HIM SHE/HER

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

BIRTHDATE: _____ SEX: _____ MARITAL STATUS: _____ SOCIAL SECURITY #: _____

PREFERRED LANGUAGE (please circle): English; Russian; Spanish; Tagalog; Other: _____

RACE (please circle): American Indian or Alaskan Native; Asian; Black or African American; Caucasian/White; Native Hawaiian or Other Pacific Islander

ETHNICITY (please circle): Non-Hispanic; Hispanic

REQUIRED PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____ PHONE: _____

REFERRING DR (FIRST & LAST): _____ PHONE: _____

PRIMARY CARE DR (FIRST & LAST): _____ PHONE: _____

GUARANTOR INFORMATION –*ONLY FILL OUT IF PATIENT IS UNDER 18 YEARS OLD*

GUARANTOR NAME: _____ PHONE: _____

ADDRESS (If different from patient): _____

CITY, STATE, ZIP: _____

FINANCIAL AGREEMENT

The financial policy of the practice has been given to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred in the collection of this account, or if my insurance later determines my services to be non-covered or not a benefit. The patient is responsible for all authorizations/referrals needed to seek treatment in our office, and must inform the office of all insurance changes. There are certain elective office and surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to procedure.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

NO SHOW/MISSED APPOINTMENT FEE

I understand that if I miss an appointment with Retina Consultants of Seattle without canceling or rescheduling that my account may be subject to a $50 fee that will not be billed to my insurance carrier.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

PRIVACY POLICY (HIPAA)

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Telephone: We may leave a message with a callback number or appointment reminder on voicemail.

Written communication: We may mail postcards to your home address or send you an e-mail.

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it.
By listing the names and signing below, I give permission to Retina Consultants of Seattle, including the technicians and doctors, to speak with the following family members/friends regarding my healthcare.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance programs be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____