Retina Specialists

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Physicians Pavilion West
6569 North Charles St.
Suite 605
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(410) 296-9700
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Frederick
77 Thomas Johnson Drive
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Columbia
9700 Patuxent Woods Drive
Suite 110
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(410) 772-9700
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www.retinaspec.com

Dear New Patient:

We would like to take this opportunity to welcome you to Retina Specialists, and thank you for choosing our group. We are confident that our expertise in the latest technological advancements will provide you with the best possible options for your retinal health care.

Enclosed, please find a **New Patient Questionnaire** for you to complete in order to make your first visit with us as comfortable and comprehensive as possible. Please complete this form before you arrive for your first scheduled appointment. Please plan for at least a 2 – 3 hour appointment as a new patient; this will provide adequate time should special testing be required.

We will ask to view all of your current insurance cards at each of your appointments. Please remember to bring them to every appointment.

We have also enclosed a Financial Policy. Please read it carefully, sign it, and bring it with you to our office on the day of your appointment along with the questionnaire. Some sections may not apply to you depending on the type of insurance coverage you have.

If you have any questions regarding the Questionnaire or the Financial Policy, you may contact either our front desk at (410) 296-9700 or our billing department at (410) 296-9706. Our staff will be happy to discuss your concerns. You can also visit our website at ***www.retinaspec.com*** for additional information.

Thank you again for this opportunity to serve you.

Sincerely,

Retina Specialists

Patient Name: ______________________ **Acct No.** ____________

LIST OF AUTHORIZED CONTACTS WITH WHOM RETINA SPECIALISTS CAN DISCUSS YOUR PERSONAL HEALTH INFORMATION AND/OR FINANCIAL INFORMATION

It is not necessary to list your physicians since we are allowed to communicate with them

Name / Address / Phone Number	Relationship	PHI type
Name: ______ Address: ______ ______ Phone: ______	Relationship: Spouse ☐ Child ☐ Other ☐ ______	Health ☐ Financial ☐ Appts ☐
Name: ______ Address: ______ ______ Phone: ______	Relationship: Spouse ☐ Child ☐ Other ☐ ______	Health ☐ Financial ☐ Appts ☐
Name: ______ Address: ______ ______ Phone: ______	Relationship: Spouse ☐ Child ☐ Other ☐ ______	Health ☐ Financial ☐ Appts ☐
Name: ______ Address: ______ ______ Phone: ______	Relationship: Spouse ☐ Child ☐ Other ☐ ______	Health ☐ Financial ☐ Appts ☐
Name: ______ Address: ______ ______ Phone: ______	Relationship: Spouse ☐ Child ☐ Other ☐ ______	Health ☐ Financial ☐ Appts ☐

______________________________ ______________

Patient Signature **Date**

Patient Registration Form

Last Name | First Name | Middle Initial

Street Address | Apt No. | City | State | ZIP

( ) | ( )

Home Telephone Number | Other Telephone Number (work, cellular, etc)

Date of Birth | Sex | Marital Status | Spouse's Name

Social Security Number

Employer | Patient Occupation

Employer Address

Referring Physician Name | Address

Do you have a Health Care Power of Attorney (POA)/Personal Representative? If yes, provide name and a copy of this document.

Please give your insurance cards to the front desk when you return this form

Insurance Information

Person responsible for charges not paid by insurance (if not patient) | Phone Number

Street Address | Apt No. | City | State | ZIP

Primary Insurance Company

Policy Holder Name | Policy Number

Secondary Insurance Company

Policy Holder Name | Policy Number

For HMO Subscribers - Primary Care Physician | Phone Number

Street Address | Apt No. | City | State | ZIP

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Financial Policy

Thank you for choosing Retina Specialists as your health care provider. We are committed to providing the best possible service and treatment so that your visit will be a success.

Please understand that payment of your bill enables us to maintain our standard of care. All patients must complete our Medical History Form and our Financial Policy Form before seeing your physician. Our office policy requires that we scan your insurance card(s) at every visit. You are responsible for providing us with your insurance information and keeping it up-to-date. If we experience a claim denial because your information is outdated or incorrect, any balance due becomes your responsibility.

If you would like to directly submit charges to your insurance company, we will provide you with the necessary documentation. Payment for services rendered to you will be due at the time of your visit.

We accept cash, checks, Visa, MasterCard, Discover, or American Express.

Medicare

All of our physicians participate with Medicare and accept assignment. However, this does not mean that we accept Medicare payment as payment in full. Your co-pay is due and payable at the time of your visit. We will bill your secondary insurance company provided you supply us with that information. If Medicare is your only insurance, or your secondary insurance does not remit payment within 30 days, the balance will become your responsibility. If you have a third insurance provider, you will be responsible for paying any balance due to us and then filing a claim with that insurance company.

Commercial Insurance Companies (for patients without Medicare insurance)

As a courtesy to you, we will submit claims to no more than two commercial insurance companies provided we have the company's name and complete mailing address. If payment is not received from your insurance provider(s) within 30 days, as required by Maryland law, the balance will become your responsibility.

HMO/PPO Insurance

All of our physicians participate with various HMO/PPO insurance companies. If you need clarification as to whether we participate with your HMO/PPO, please call our office. It is your responsibility to obtain all referrals and authorizations for office visits prior to your appointment. If a valid referral or authorization is not available, you will need to sign a waiver making you responsible for the charges or we will reschedule your appointment. We accept cash, check, Visa, MasterCard, Discover, and American Express.

(over, please)

Patients without Insurance Coverage

If coverage by an insurance company is not active for the date of service, you will be required to pay 50% of the charges for that visit at the time the services are rendered. The remaining 50% will be billed to you and is payable within 30 days of receipt of the bill.

Medical Assistance of Maryland

All of our physicians participate with Maryland Medicaid. On the day of your visit, we will call to verify that your coverage is active. If coverage is active, we will bill Medicaid for you. If coverage is not active, the guidelines for patients without insurance will apply.

Medical Assistance for states other than Maryland

Because Medicaid coverage and reimbursement is controlled separately by each state, we will not be able to accept Medicaid from states other than Maryland. Please refer to the guidelines above for patients with no insurance coverage.

Payment of Balances Due

In the event that your insurance company sends payment for services directly to you, it is your responsibility to forward the payment along with a copy of the explanation of benefits to our office.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's arbitrary determination of what constitutes "usual and customary rates."

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Acceptance and Authorization to Bill Insurance

I have read, understand, and agree to this Financial Policy. By my signature below, I request that payment of authorized benefits be made on my behalf to Thompson & Sjaarda, P.A. dba Retina Specialists for services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company or any third-party payer any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient Date

Signature of Responsible Party (if patient is unable to sign) Date

Retina Specialists

Patient Questionnaire

Name: Birth Date:

Current or Previous Occupation:

Contact Person: Phone of Contact Person:

Family Doctor or Internist: Doctor's Phone:

Doctor's Address:

What is the main ocular reason for your visit today? Please describe the problem:

Severity: 1 2 3 4 5
(Mild) *(Moderate)* *(Severe)*

Timing: Sudden Gradual

Duration: ____ Hours ____ Days ____ Weeks ____ Months

Associated signs and symptoms:

Please Answer Every Question Yes or No - Thank You!

Have you ever had any of the following eye problems?

Yes	No		When
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Cataract	
☐	☐	Corneal disease	
☐	☐	Laser Treatment	
☐	☐	Diabetic Retinopathy	

Family History

Do any of your family members have:

Yes	No		Relationship to Patient
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Diabetes	

Patient's Name _____

Have you ever had any of the following other problems?

Yes	No		Please Elaborate (When, Type)
☐	☐	Diabetes	How long?
☐	☐	Problems with your Endocrine System (Pancreas, Thyroid)	
☐	☐	High Blood Pressure	How long?
☐	☐	Heart Problems (Heart Attack or Disease)	
☐	☐	Do you have a pacemaker or a defibrillator?	
☐	☐	Problems with your Blood or Excessive Bleeding	
☐	☐	Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema)	
☐	☐	Kidney Disease	
☐	☐	Stroke	
☐	☐	Cancer - What Kind	
☐	☐	Liver Disease (Hepatitis, Jaundice)	
☐	☐	Lupus	
☐	☐	Urinary Problems	
☐	☐	Neurologic Problems (Numbness, Seizures, Paralysis)	
☐	☐	Muscle or Joint Problems (Arthritis, etc.)	
☐	☐	Problems with your Immune System	
☐	☐	AIDS / HIV	

Smoker Status: Current smoker ☐ Former smoker ☐ Never smoker ☐

Surgeries

Eye **(including cataract surgeries)**	Other surgeries
1.	1.
2.	2.
3.	3.
4.	4.

Patient's Name _____

Medications

Please list all medications you take, including eye drops. ***If you have a list, check here ___ and we will copy it.***

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes**: If yes, list drug and type of reaction:

_____

_____

Review of Systems-Eye

Do you now have, or have you ever had, any of the following problems?

Yes	No		Yes	No	
☐	☐	Loss, Distorted, or Fluctuating Vision	☐	☐	Eye Pain/Soreness
☐	☐	Loss of Side Vision	☐	☐	Blurred Vision
☐	☐	Flashes of Light	☐	☐	Eye Injury
☐	☐	Floaters	☐	☐	Double Vision

Review of Systems-General

Do you now have, or have you ever had, any of the following problems?

Yes	No		**Please elaborate (when, type)**
☐	☐	Hay Fever/Sinus Problems	
☐	☐	Recent Fever or Weight Loss	
☐	☐	Digestive Problems, or Changes in Bowel Habits	
☐	☐	Skin Problems (Rashes, Excessive Dryness)	

Advanced Directives

Yes	No	
☐	☐	Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury?

_____

Person completing form | Relationship (if not the patient) | Date