Retina Specialists

Raymond N. Sjaarda, M.D.
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David E. Barañano, M.D., Ph.D.

www.retinaspec.com

Dear New Patient:

We would like to take this opportunity to welcome you to Retina Specialist, 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 lease 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 <u>each</u> of your appointments. Please remember to bring them to <u>every</u> 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 your 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 Specialist

Retina Specialists
DR. THOMPSON • DR. SJAARDA • DR. BARANANO

Patient Registration Form

Last Name | First Name | Middle Initial

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

( ) | ( )

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

Date of Birth. | Sex | Martial Status | Spouse's Name

Email Address | Social Security Number

Ethnicity | Race

Employer | Patient Occupation

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.

Insurance Information

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

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

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

Primary insurance Company

Policy Holder Name. | Policy Holder DOB | Policy Number

Secondary Insurance Company

Policy Holder Name. | Policy Holder DOB | Policy Number

For HMO Subscribers – Primary Care Physician | Phone Number

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

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New Patient Questionnaire

MRN: _____

Name: _____ Height: _____ Weight: _____

Phone Number: _____ Birth Date: _____

Referring (eye) Doctor: _____ Phone: _____

Primary Care Doctor: _____ PCP Phone: _____

Doctor's Address: _____

Reason for visit: _____ **When did it start?** _____

Since onset has the problem: Improved Remained the same Continued to get worse

Please Check <u>Every</u> Question Yes or No – Thank you!

Have you been diagnosed with any of the following problems?

Eye Health:

Yes	No		Details
		Blindness	
		Cataract	Which eye(s)?
		Corneal Disease	
		Diabetic Retinopathy	
		Glaucoma	
		Laser Treatment	For what?
		Macular Degeneration	
		Retinal Detachment	

Eye Treatment or Surgeries, indicate which eye:

1. _____ 3. _____

2. _____ 4. _____

Review of Systems
Are you experiencing any of these problems?

Yes	No		Yes	No	
		Eye Pain			Diabetes
		Poor Vision			High Blood Pressure
		Loss of Vision			Allergies
		Redness			Pacemaker

Family History:

Yes	No		Relationship to Patient
		Diabetes	
		Glaucoma	
		Macular Degeneration	

General Health:

Yes	No		Details
		Arthritis	
		Asthma	
		Autoimmune Disease	What type?
		Cancer	What type?
		Diabetes I	A1c:
		Diabetes II	A1c:
		Heart Problems (Heart Attack or Disease)	
		High Blood Pressure	
		HIV/ AIDS	
		Kidney Disease	
		Liver Disease (Hepatitis, Jaundice)	
		Neurologic Problems (Numbness, Seizures, Paralysis)	
		Problems with your Blood or Excessive Bleeding	
		Stroke	When?
		Thyroid Disease	What type?

General Surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

Have you had a flu shot this season? ☐ No ☐ Yes

Have you ever had a pneumonia vaccination? ☐ No ☐ Yes: When? _____

Medications and Supplements:
Please list all medications and supplements 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:** List drug and type of reaction:

_____

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 this form | Relationship (If not the patient) | Date

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Patient Name: ______________________________ **MRN 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/ Phone Number	Relationship	PHI Type
Name: ____________________ Phone: ____________________	Spouse ☐ Child ☐ Other ☐ ________	Health ☐ Financial ☐ Appointments ☐
Name: ____________________ Phone: ____________________	Spouse ☐ Child ☐ Other ☐ ________	Health ☐ Financial ☐ Appointments ☐
Name: ____________________ Phone: ____________________	Spouse ☐ Child ☐ Other ☐ ________	Health ☐ Financial ☐ Appointments ☐
Name: ____________________ Phone: ____________________	Spouse ☐ Child ☐ Other ☐ ________	Health ☐ Financial ☐ Appointments ☐
Name: ____________________ Phone: ____________________	Spouse ☐ Child ☐ Other ☐ ________	Health ☐ Financial ☐ Appointments ☐

______________________________ ______________

Patient Signature **Date**

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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. There is a $30.00 fee charged for a check returned for any reason.

We accept cash, check, Visa, MasterCard, Discover, or American Express

Medicare

All of our physicians participate with Medicare and accept assignment. However, this does not mean that they accept Medicare payment in full. Your cop-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 that 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 HMP/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.

Patients without Insurance Coverage

If coverage by an insurance company is not active for the date if service, you will be required to pay 50% if the charges for that visit at the times 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 are 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 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. I also understand and acknowledge that I am personally responsible to pay Retina Specialists in full for services that my health insurer will not cover due to non-payment of health insurance premiums.

Signature of Patient Date

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