Name:
Chart:
Date:

THE RETINA GROUP
OF WASHINGTON

PATIENT REGISTRATION FORM

First Name		MI	Last Name		Sex
Home Address			**City**	**State**	**Zip Code**
Home Phone	**Work Phone**		**Cell Phone**	**Preferred method of contact**	
Date of Birth	**Age**	**Social Security Number**	**Marital Status** ❑ S ❑ M ❑ D ❑ W	**E-mail Address**	
Preferred Pharmacy Name, Address, and Phone					

I agree that The Retina Group of Washington, PC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Signature: ______________________ **Date:** ____________

Race		Ethnicity	Preferred Language
☐ African American/Black	☐ Asian	☐ Hispanic or Latino	(please specify)
☐ American Indian or Alaska Native	☐ White/Caucasian	☐ Non-Hispanic/Non-Latino	______________
☐ Native Hawaiian or other Pacific Islander	☐ Decline to provide	☐ Decline to provide	

Patient Employer / Occupation (Indicate if student)	Financially Responsible Person ❑Patient ❑Spouse ❑Parent ❑Other	Name(if different from patient)
Financially responsible persons address (if different from patient)	**Home phone**	**Work phone**
Is patient residing in Skilled Nursing Facility? ❑ yes ❑ no	**If yes, name and address of facility**	**Facility phone number**
Emergency Contact	**Relationship**	**Phone number**
Referring Physician		**Phone number**
Primary Care Physician		**Phone number**

INSURANCE INFORMATION

Primary insurance:
Carrier: ______________ **Address:** ______________________ **Phone:** ______________
ID# ______________ **Group#** ______________ **Effective Date:** ______________
Policyholder: ______________ **Policyholder SSN:** ______________ **DOB:** ______________

Secondary Insurance:
Carrier: ______________ **Address:** ______________________ **Phone:** ______________
ID# ______________ **Group#** ______________ **Effective Date:** ______________
Policyholder: ______________ **Policyholder SSN:** ______________ **DOB:** ______________

Tertiary Insurance:
Carrier: ______________ **Address:** ______________________ **Phone:** ______________
ID# ______________ **Group#** ______________ **Effective Date:** ______________
Policyholder: ______________ **Policyholder SSN:** ______________ **DOB:** ______________

Name:
Chart:
Date:

FINANCIAL POLICY STATEMENT

Welcome to the Retina Group of Washington, P.C. We are pleased you have chosen our practice for your medical care. We would like you to know that we are committed to providing the highest quality of services available. As your medical care provider, our relationship is with you and not your insurance carrier. Therefore as a courtesy to you, we will file your claim with your insurance company. However, we ask that you **carefully read and sign** your understanding and agreement to the following:

- You are the sole responsible party for all charges incurred and guarantee payment thereof.
- If we are contracted with your insurance company and/or Medicare, we will accept assignment.
- You will be responsible for your payment portion at the time of service
- Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing will result in all charges for services to become the sole responsibility of the patient/responsible party.
- You are expected to understand your benefits coverage and responsibility which includes obtaining any referrals and/or authorizations your insurance company requires before care is provided.
- All copays, co-insurance and deductibles are due and payable at the time service is rendered.
- If we do not have a contractual obligation with your insurance company you are responsible for 100% of the payments at the time services are rendered.

In consideration of the services rendered by The Retina Group of Washington, P.C., you hereby agree to abide by the term of this Financial Statement and must therefore select one of the following options:

______ **Option A (Patient Authorization)**

I hereby authorize The Retina Group of Washington, P.C. to apply for benefits on my behalf for services rendered. I request payment from Medicare, MediGap, and/or ____________________ be made directly to The Retina Group of Washington, P.C.

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information including medical information this or any related claim to the above named

______ **Option B** (Opt-Out)

I **do not** wish for The Retina Group of Washington, P.C. to disclose information concerning my visit and/or services to my insurance carrier for benefits or payment. By selecting this option I understand that I will be responsible for paying for all care out-of- pocket in full at the time of visit.

- ☐ I authorize this option to apply to **all** visits/appointments
- ☐ I authorize this option to apply to the following date(s) of services: ____________________

Patient Signature: ______________________________ Date: ____________________