PATIENT INFORMATION FORM

E-mail: ______________________ Today's Date: ____________

Patient's name ______________________
Last First Middle

Address: ______________________ Home telephone: ____________

City, state, zip ______________________ Cell phone #: ____________

Date of birth: ____________ Sex: ________ Race: ______ Social Security #: ____________

Marital status: ❑ Single ❑ Married ❑ Divorced: ❑ Widowed: Ethnicity: ____________

Employer: ______________________ Work telephone: ____________

Occupation: ____________ Retired: ❑ Yes ❑ No Disabled: ❑ Yes ❑ No

If retired, name of company retired from: ____________ Retirement date: ____________

Doctor who referred you to us: ______________________

If not physician referred, how did you hear of our practice ❑ Friend ❑ Internet ❑ Other ____________

Medical Doctor/Diabetic doctor: ____________ Preferred Language: ____________

Pharmacy Name: ____________ Telephone #: ____________

Spouse's Name: ____________ Date of Birth: ____________

Social Security #: ____________ Spouse Cell Phone #: ____________

Employer: ____________ Work Telephone #: ____________

Person to Contact in Case of Emergency (Not Living With you):

Name: ______________________ Telephone #: ____________
Relationship

BILLING INFORMATION

Primary Insurance

Name of Insurance: ______________________

Contract #: ____________ Group Name: ____________ Group #: ____________

Name of Policy Holder: ____________ Policy Holder's Date of Birth: ____________

RELATIONSHIP TO POLICY HOLDER: ____________

Secondary Insurance

Name of Insurance: ______________________

Contract #: ____________ Group Name: ____________ Group #: ____________

Name of Policy Holder: ____________ Policy Holder's Date of Birth: ____________

RELATIONSHIP TO POLICY HOLDER: ____________

Work Comp / Voc Rehab / Other?

Eye Injury? ____________ Which Eye? ____________ Date of Injury: ____________

PLEASE SIGN RELEASE OF INFORMATION AUTHORIZATION ON BACK OF THIS FORM

Registered by: ____________ Account #: ____________ Date: ____________

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Person Responsible For Bill: ______________________________

Father's Name:	____________	Social Security #:	____________
Address:	____________	Home Telephone:	____________
Employer:	____________	Date of Birth:	____________
Occupation:	____________	Work Telephone #:	____________
Mother's Name	____________	Social Security #:	____________
Address:	____________	Home Telephone:	____________
Employer:	____________	Date of Birth:	____________
Occupation:	____________	Work Telephone #:	____________

EXPLANATION OF COLLECTION AND CHARGES
(A LIST OF CHARGES WILL BE FURNISHED UPON REQUEST)

PAYMENT POLICY

PAYMENT ARRANGEMENTS MUST BE MADE AT THE TIME SERVICE IS RENDERED. I UNDERSTAND THAT RETINA SPECIALISTS OF ALABAMA IN MONTGOMERY, LLC ("THE PRACTICE"), MAY ASSIST WITH FILING OF INSURANCE FORMS, BUT I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

AGREEMENT TO PAY

Assignment of Benefits and Guarantee of Account: In consideration of all services and supplies provided by Retina Specialists of Alabama in Montgomery, LLC, I understand and agree that I have full responsibility to pay Retina Specialists of Alabama in Montgomery, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Retina Specialists of Alabama in Montgomery, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Retina Specialists of Alabama in Montgomery, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
I agree, in order for Retina Specialists of Alabama in Montgomery, LLC to coordinate my care, service my account or to collect monies I may owe, Retina Specialists of Alabama in Montgomery, LLC and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Retina Specialists of Alabama in Montgomery, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from the above authorizations and agreements.

APPOINTMENT REMINDER POLICY

I authorize this Practice and their agent to place appointment reminder phone calls to the phone number I have listed on my patient form.

CONSENT TO TREATMENT

I authorize the physicians of the Practice, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and have-been advised not to drive. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: ______________________________ Date: ______________

______________________________ ______________

______________________________ ______________