PATIENT ACKNOWLEDGEMENT

PATIENT NAME: ____ ID: ______________________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Our Patient Rights and Responsibilities describes your rights under the law. You have the right to review our Notices before signing this acknowledgement. By signing this form, you acknowledge that you were provided a copy of the Retinal Consultants of Arizona Notice of Privacy Practices and Patient Rights and Responsibilities. These notices describe the use and disclosure of protected health information about you for treatment, payment, health care operations, and other uses and disclosures as stated. They also describe certain patient entitled rights and certain patient responsibilities to fulfill healthcare needs.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Retinal Consultants of Arizona has a Notice of Privacy Practices and Patient Rights and Responsibilities and the patient has the opportunity to receive a paper copy of these Notices.
- Retinal Consultants of Arizona reserves the right to change the Notice of Privacy Practices and Patient Rights and Responsibilities at any time. A current copy of these notices may be obtained by contacting our office.
- Retinal Consultants of Arizona will also use and share your health information as required/permitted by law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON REQUEST

I, ___________________________, give my permission to disclose protected health information from my health records, including financial information, to the following person(s).

Name(s): ____

Patient Signature: ____ Date: __________________________

AUTHORIZATION TO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Retinal Consultants of Arizona for any and all services provided to me by Retinal Consultants of Arizona. If my health insurance will not allow direct payment to Retinal Consultants of Arizona or if Retinal Consultants of Arizona chooses not to accept assignment of medical benefits, I agree to immediately forward to Retinal Consultants of Arizona any and all health insurance payments I receive. I acknowledge that I am responsible for all charges for services provided by Retinal Consultants of Arizona, including any non-covered services or amounts not paid by insurance. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers.

Printed Patient Name: ____

Signature: ____ Date: __________________________

Relationship to patient (if other than patient): ____

GENERAL CONSENT TO TREAT

By signing below, I authorize the health care providers at Retinal Consultants of Arizona, to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnosis and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to the alternatives, including the possible results of not choosing to undergo the recommended treatment.

I consent to the presence of students, trainees, observers, medical sales representatives, and/or non-facility personnel as deemed necessary and/or appropriate at the discretion of my physician and/or the management of Retinal Consultants of Arizona.

Printed Patient Name: ____

Signature: ____ Date: _____________________________

Relationship to patient (if other than patient): ____

Retinal Consultants Of Arizona Ltd

1101 E Missouri
Phoenix, AZ 85014-2709
USA
(602) 222-2221

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	CURRENT GENDER	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ______________

AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

Patient's Name	Date of Birth	Medical Record Number
Address		Phone Number

I hereby request access to the Protected Health Information ("PHI") record from this date: _________________ to this date: _________________ maintained or created by the provider named below to the recipient named below.

- ☐ Progress/Chart Notes
- ☐ Billing Records
- ☐ Entire health record
- ☐ Other: ____________________________________

Delivery of Records:
- ☐ I will pick up my records.
- ☐ Please send my records to the Patient Portal.
- ☐ Please fax my records to the number below.
- ☐ Please mail copies of my records to the address below.

	Records From	Records To
Name		
Address		
Phone		
Fax		

Purpose of Request:
☐ Patient's Request ☐ Referral/Continuing Medical Care ☐ Other: _________________________________

By signing below, I understand:
- ➢ I may revoke this authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- ➢ Unless the purpose of this authorization is to determine payment of a claim or benefits, RCA may not condition the provision of treatment or payment for my care on my signing of this authorization.
- ➢ The information disclosed pursuant to this authorization may be redisclosed by the recipient and may not be protected under the HIPAA regulations.

Patient's Full Legal Name	Date of Birth
Signature of Patient/Parent/Legal Representative	Date

***** **For Internal Use: Please retain a copy of this form for six (6) years.****
Identity of requestor verified via: ☐Photo ID ☐Matching Signature ☐Other (specify): ______________________
Records Sent by (Print Name)____________________________________on (date) ______________________

RESPONSIBLE PARTY INITIAL THE FOLLOWING, AS RECORD OF FINANCIAL DISCLOSURE:

_____1. I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at **Retinal Consultants of Arizona (RCA)**. Please check with your insurance carrier, prior to your visit, to fully understand anticipated out of pocket costs.

_____2. I understand that RCA will collect ***Estimated fees***, at or prior to surgery and clinic visits, which include co-payments, deductibles, coinsurance, unpaid balances and non-covered services. Cash, checks, MasterCard, Visa, Discover, and Debit Cards are accepted. Payment is due upon receipt of statement for balances not covered by my health plan. If my insurance pays me directly for services billed by RCA it is my obligation to forward the payment to RCA.

_____3. I understand that RCA accepts both vision and medical plans. Vision plans cover routine eye exams and eyeglasses/contact lenses. All other billable services are usually sent to medical plans.

_____4. I understand that a refraction fee will be collected, following services, if I do not carry vision benefits and/or after surgery during the final post-operative visit if testing is necessary (only for patients receiving post op care at RCA).

_____5. I request that payment of authorized medical benefits be made on my behalf to all related entities involved or participating in my eye care associated with RCA. I authorize release of medical information necessary to my claim(s).

_____ 6. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash).

_____7. I understand the following No Show/Cancellation Policy:

- ***Clinic appointments*** canceled less than a 24 hour advance notice or failure to show up for an appointment will be charged a $25 fee for the first occurrence, $50 for two or more occurrences. If I arrive 30+ minutes late for an appointment, I may be rescheduled at the physician's discretion.
- ***Surgery appointments*** canceled less than a 48 hours advance notice or failure to show up for an appointment, without immediate rescheduling, will be charged a $100 fee.
- ***Oculoplastic Surgery appointments*** canceled less than a 17 day advance notice or failure to show up for an appointment, without immediately rescheduling, will be charged a $250 fee (functional appointment) or 15% of the charge estimate provided (cosmetic appointment).

_____ 8. I understand that my credit card information will be kept securely on file. It will automatically be charged for amounts not covered by insurance for services, outstanding balances, deductibles, copayments and arrangements established between myself and the RCA billing department.

_____ 9. I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for paying these fees.

_____10. I understand that if my account has a patient responsibility amount that is not paid within 90 days then my account will be placed with an outside collection agency. No additional appointments may be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.

_____11. RCA will charge a fee of $50 for the completion of forms/paperwork which is due at the time of the request. Forms received directly from you or your employer takes considerable time to complete. The turnaround for completion can take up to fifteen days.

STATEMENT OF FINANCIAL RESPONSIBILITY: I acknowledge that I am responsible for all charges for all services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and understand the above Financial Policy and I agree to abide by its terms.

Printed Name of Patient: ____ID:_______________

Signature of Patient/ Responsible Party: ____ Date: _____________