Highland Retina Associates LLC

PATIENT INFORMATION SHEET

□Mr. □Mrs. □Ms. First Name: ______________________ MI: ____ Last Name: ________________________

Mailing Address: ____________________________ City: ____________________ State: ________ Zip: ______________

Patient's Date of Birth: ____________________ Age: __________ Sex: _______ Today's Date: ____________

Home Phone: _____________________ Work Phone: ______________________ Cell Phone: _____________________

Marital Status: _________ Social Security Number: _____________________

Race: ________________ Language: _________________ E-mail:____

Receive appointment reminders via: EMAIL TEXT PHONE CALL (You can select up to 3)

Employed: **Y N** (if yes) Full time Part-time Self Retired Military Occupation: _____________________

PRIMARY INSURANCE INFORMATION: ☐ **Commercial** ☐ **Medicaid** ☐ **Medicare** ☐ **Self Pay**

Insurance Company: ______________________________ ID#: _____________________ GROUP#: _______________

Insured's Full Name:____________________________ **DOB**:___________ **SSN#:** ___________________________

Relationship to Patient: Self ____ Spouse____ Child____

SECONDARY INSURANCE INFORMATION: **PLEASE NOTE WE DO NOT ACCEPT RETRO ACTIVE MEDICAID**

Insurance Company: ______________________________ ID#: _____________________ GROUP#:_______________

Insured's Full Name:________________________________ **DOB:**____________**SSN#:** _________________________

Relationship to Patient: Self _____ Spouse _____ Child____

Preferred Pharmacy: _____________________________ ***Town:*** __________________***Phone #:***____________________

Emergency Contact Name: _________________________________ Relationship: _________________

Phone Number: _________________________ Address: ____

REFERRING PHYSICIAN: **FAMILY PHYSICIAN:**

Name: _________________________City:__________ Name: ____________________ City: __________

PLEASE READ AND SIGN BELOW

I hereby authorize the physician and staff of Highland Retina Associates LLC to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physicians during any and all visits to HRA, I understand that I am financially responsible for ALL charges arising from services rendered to me by HRA.

Signature: ____ Date: ________________HRA Doctor______________

History Reviewed by: __________________M.D. _________Date

Highland Retina Associates LLC

RELEASE OF INFORMATION:

I hereby authorize Highland Retina Associates LLC to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

I permit a copy of this authorization to be in place of the original.

Signature of Patient: ____ Date: ______________________________
OR
Signature of Other
Responsible Person: ____ Date: ______________________________

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Highland Retina Associates LLC.

I further hereby authorize payment directly to HRA, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to HRA for changes not covered by this authorization.

I will cooperate in seeking, collecting, and paying to HRA, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to HRA, I agree to collect payment and pay to HRA with in five (5) days of receipt. Unless prior arrangements have been made regarding payment to Highland Retina Associates LLC.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient: ____ Date: ______________________________
OR
Signature of Other
Responsible Person: ____ Date: ______________________________

The Following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Highland Retina Associates LLC to share my protected health information with (not including other doctor offices):

____ ____

Name Relationship/Phone No. Name Relationship/Phone No.

____ ____

Name Relationship/Phone No. Name Relationship/Phone No.