Dear Patient,

Welcome to Retina Consultants of Southwest Florida! Your visit with us will last approximately 2 to 3 hours. Your time is very valuable to us, and we understand that our visits are long. We make every effort to complete as many tests or procedures that you may require for your condition so that we may reduce the need for additional visits.

Your eyes will be fully dilated to ensure a thorough retina exam and may be dilated for 24-36 hours afterward. For safety, we recommend that someone drive you home from each visit.

Please bring the following to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses
- Completed Pink Medical History Form with a current list of your medications
- Completed Yellow Patient Information Form
- Sunglasses to wear after your appointment

Please review the attached Insurance/Financial Information Policies letter, and please do not hesitate to ask any questions.

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much!

The Doctors and Staff of Retina Consultants of Southwest Florida

Insurance / Financial Information

At Retina Consultants of Southwest Florida, we understand how confusing medical insurance sometimes can be. Please review the following information which should help answer some of the basic questions about the insurance plans we accept and the process in which we work with your insurance company.

Medicare

All of our physicians participate with this government plan. As per our Medicare contract, our practice will decrease our fees to the Medicare allowed amount. Medicare will pay 80% of the allowed and our practice collects the remaining 20% from the patient or supplemental insurance. Medicare deductibles may be the responsibility of the patient.

- If your supplemental plan is a Medigap, Medicare Crossover Plan, or Contracted Managed Care Plan, we will submit claims for the Medicare 20% payment. You will be billed for any amount not paid by your health plan.

- If your supplemental plan is NOT a Medigap, Medicare Crossover Plan, or Contracted Managed Care Plan, you will be responsible for filing your claim for reimbursement and we will collect the 20% co-payment at the time services are rendered.

- If the annual Medicare deductible is charged against our claims, we will submit a claim to the Medigap, Medicare Crossover, or Contracted Managed Care Plan supplemental insurance. If this is not paid, we will send a statement to you for payment.

Medicare Replacement Plans

There are two types of Medicare Replacement Plans: Managed Care Plans and Non-Managed Care Plans.

<u>Managed Care Plans (HMO/PPO)</u>: These insurance carriers require the physician to sign a contract to participate with their plans. Please check with our office staff to determine if your plan is one that our practice participates with. We will verify insurance benefits on all Medicare Replacement plans. For those plans we do not participate with, the benefits of your plan will determine whether or not we will collect at the time of service. We will always file a claim to the Medicare Replacement plans, but payment, at the time of service, may be the patients' responsibility.

<u>Non-Managed Care/Private Fee For Service (PFFS)</u>: These plans and their carriers agree to pay our office at Florida Medicare allowable rates. We will work with the carrier in submitting claims to obtain payment. If the carrier does not pay Florida Medicare rates, we will appeal to the carrier for the additional amount due, however, if the appeal is unsuccessful, the patient will be responsible for the payment.

We will collect any applicable co-payments at the time services are rendered as indicated by your insurance carrier benefit verification

Medical Urgent and Emergent Care: Should the insurance benefit verification determine you only have Urgent and Emergent Care Coverage, and your services are not urgent/emergent you will be responsible for paying the Florida Medicare Allowed fee for all services rendered

Commercial Insurance Carriers

There are two different types of commercial insurance carriers: Managed Care and Traditional carriers.

Our practice has signed participation contracts with many Managed Care commercial carriers. Please check with our staff to determine if your individual plan is on that we participate with.

If we do participate with your plan, we will submit a claim for payment of services rendered. We will collect any and all applicable co-payments, deductibles and out-of-pocket amounts at the time services are rendered.

If your plan is one we do not participate with, we will expect payment for all services at the time they are rendered. A receipt will be given to you that will list all of the information necessary for you to file a claim to your carrier for potential reimbursement for our services. We advise you to check with your plan to verify what your benefits and rights are when seeing a physician outside of your managed care network.

Traditional Plan simply means the insurance coverage is not a managed care plan and the provider does not have any contractual obligation to the plan or the patient. If you have a Traditional plan, a receipt will be given to you to file a claim to your carrier for reimbursement of our services. We will collect for all services rendered at the end of your visit.

If you have any financial questions or concerns, our staff is here to help you. Please contact one of our Patient Account Specialists at (239) 936-7340. Please listen to the prompts which will direct you to the correct specialist. Long distance, please call 1-800-282-8281 and request to speak with a Patient Account Specialist.

Welcome

Thank you for choosing Retina Consultants of Southwest Florida. Please provide us with the information requested below. See a staff member if you need any assistance completing this form.

Name____

Last First Middle

Birthdate: ____/____/______ Sex: M F (please circle)

Patient's Social Security Number:___________________________________

E-Mail Address:____

Local Address:

____

Street City State Zip

Home Phone (______) ________________________ Cell Phone (______) _______________

Mailing Address, if different:

____

P.O. Box City State Zip

Northern Address:

____

Street City State Zip

Northern Phone: (_____) ________________________________

The following information is collected per Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your response is optional.

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African America
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unreported/Not Known

Primary Language Spoken: ____

Ethnicity: ☐ Hispanic or Latino ☐ Not Reported ☐ Not Hispanic or Latino

Information from your visit(s) may be shared with the physicians you list below unless you instruct us otherwise.

Referring Physician: (Please provide address if physician is not local)

____
Name Phone Address, City, State, Zip

General Eye Care Physician: (If different from Referring Physician listed above)

____
Name Phone Address, City, State, Zip

Primary Care / Family Physician:

____
Name Phone Address, City, State, Zip

Many times patients want us to be able to discuss their medical care with family members or friends. Please list all people that we are permitted to discuss these matters with.

1. ___________________________ Relationship: _________________ Date of Birth:

2. ___________________________ Relationship: _________________ Date of Birth:

3. ___________________________ Relationship: _________________ Date of Birth:

Please indicate someone we may contact other than your spouse for emergency purposes.

Name:___________________________________ Phone: ( )

Relationship:_____________________________ Date of Birth:_____________________

Often times, people find it convenient for us to leave test results on their answering machine. May we leave test results on your answering machine?

Yes No (please circle)

Insurance Information

Please provide us with your complete insurance information below. If the primary subscriber is someone other than the patient, please indicate.

Primary Insurance Company:

Address: ____

____

Phone: (_____)______________________________

Subscriber/Member's Name:

Subscriber's Date of Birth:

Subscriber's Social Security Number:

Policy ID/Group and Contract Numbers:

If Workman Compensation Claim, please provide:

Employer's name (if applicable):

Employer's Address: ________________________________ Phone # _______________

Supplemental Insurance Company:

Address: ____

____

Phone:(_____)

Subscriber/Member's Name:

Subscriber's Date of Birth:

Subscriber's Social Security Number:

Policy ID/Group and Contract Numbers:

Patient Acknowledgment & Consent

I understand that in the course of my care and treatment by Retina Consultants of Southwest Florida, medical reports will be created. I consent to Retina Consultants sending any reports regarding my evaluation, treatment, and follow-up care to any other health care providers involved in any of my care and treatment, including the doctor requesting the consultation with Retina Consultants and my family physician. I understand that in the course of my treatment, the physicians at Retina Consultants may have to review medical reports and records from other health care providers and consent to Retina Consultants requesting and receiving those records they deem necessary.

I understand that in order to facilitate insurance or other third-party reimbursement for my care and treatment, that Retina Consultants or its agents may have to share information about me with my insurance company or third-party payment source or their agents or employees (including my employer, if this is a worker's compensation claim). I consent to Retina Consultants sharing the information necessary to properly process claims for reimbursement.

I hereby assign my right to be reimbursed out of any insurance policy or from any person or organization that is or may become liable to me for any of the costs or fees associated with my care and treatment to Retina Consultants and authorize payment directly to Retina Consultants.

I understand and agree that I am individually obligated to pay for the care and treatment provided to me, including outstanding balances not covered by any insurance policy or other third-party payment source such as Medicare. I understand and agree that if I do not pay any amounts due, that I will be liable for any costs and fees associated with collecting those amounts, including attorney's fees and court costs, if any.

_______________________________________ ________________________

Signature

Date

Retina Consultants of Southwest Florida℠

Patient Name:______________________ Date:___________Chart#:_________

Review of Systems – Medical History Form

KNOWN ILLNESSES	YES	NO
Diabetes? – Type I or Type II		
How Long?_________________ Diabetes Physician:_______________________________		
Stroke? When:______________________		
Heart Attack? When____________________		
Alzheimer's		
Migraine		
Sickle Cell Trait		

PAST MEDICAL HISTORY / SURGICAL HISTORY / RESOLVED ILLNESSES:

List Illnesses-current or resolved, not listed above	List Past Surgeries	Date

Current Medications – Please complete the list below by adding the dosage you take per day. If your medication is not already listed we have provided an area below that you can complete. Please fill in the name, dosage and circle "Rx" - Prescription medication or "OTC" Over the Counter medication.

Prescription Medication Name / Dosage / amount taken per day:

Blood Thinner: □ N/A ______________________x per day

Aspirin _______________x per day

___________________________ ______x per day Rx OTC ___________________________ ______x per day Rx OTC

___________________________ ______x per day Rx OTC ___________________________ ______x per day Rx OTC

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Allergies: - Please list all

____ Reaction: ____

____ Reaction: ____

____ Reaction: ____

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Review of Systems / Medical History Form

Patient Name:______________________ **Date**:_____________ **Chart #**:_______________

Family History: Check Yes or No as related to your Family History. Explain positive responses. ie: Mother, Father, Sister, Brother, Grandparents.

	YES	NO	Family Member		YES	NO	Family Member
Glaucoma:				Diabetes:			
Cataract:				Hypertension:			
Retinal:				Vascular:			
Cardiac:				Cancer:			

Social History:

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Number of Children: ____
Smoking: ☐ Non-Smoker – Quit __________ ☐ Smoker-packs per day? ______
Drinking: ☐ No Alcohol ☐ Alcohol - drinks per day?______
Occupation: ☐ Working ☐ Retired ☐ Other_________________________________
Driving: ☐ Yes ☐ No

Please check each item Yes or No as they relate to your health

	Yes	No		Yes	No		Yes	No
EYES			**NEUROLOGIC**			**INFECTIOUS DISEASE**		
Double Vision			Weakness			Hepatitis		
Pain			Headaches			HIV		
Floaters or Spots			Scalp Tenderness					
Seeing Flashes of light			Dizziness			**INTEGUMENTARY - SKIN**		
Dry Eyes			Paralysis of Extremities			Rash		
Decreased Vision			Tremor			Change in Mole		
Sandy/Gritty Feeling								
Excessive Tearing			**GENERAL HEALTH**			**MUSCULOSKELETAL**		
			Fever			Muscle Aches		
CARDIOVASCULAR			Weight Loss			Joint Pain		
Chest Pain / Angina			Fatigue			Difficult lying flat		
Shortness of Breath			Loss of Appetite			Why?______________________		
Swelling of Feet/Hands								
Hypertension			**Gastrointestinal (Stomach/Intestines)**			**PSYCHIATRIC**		
Blood Pressure Controlled			Abdominal Pain			Anxiety		
Murmur			Nausea			Schizophrenia		
			Diarrhea			Bipolar Disorder		
ENDOCRINE						Depression		
Excessive Thirst			**BLOOD / LYMPH**					
Excessive Urination			Easy Bruising			**GENITOURINARY**		
Heat Intolerance			Prolonged Bleeding			Pain/Burning on Urination		
Cold Intolerance			**CANCER**			Blood in Urine		
Diabetes			Location:___________________					
Blood Sugar Controlled			Radiation ☐ Chemotherapy ☐					
RESPIRATORY			**EAR, NOSE, MOUTH, THROAT**					
Wheezing			Hearing – loss / problems					
Cough			Sore Throat					
Recent Flu or Virus			Runny Nose / Sinus					
Shortness of Breath								
Sleep Apnea								

Patient Signature:_______________________________________ **Date:**_________________________________

Technician Signature:____________________________________ **Date**:__________________________________

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