Patient Registration

We require copies of all insurance cards (including Medicare cards) as well as a picture ID, please present these to the front desk.

Patient Name: ____
(Last) *(First)* *(Middle)*

MRN#_____________________________________

Date of Birth: ____ /____ /_________ Language Preferred: ____________________

Birth Sex: ☐Male ☐Female ☐Undifferentiated

Current Gender: ☐Male ☐Female ☐Other ___________________________

Race: (circle all that apply)

American Indian or Alaska native	Asian	Black or African American
Native Hawaiian or Pacific Islander	White	Decline to State
Other______________________	Unknown	

Ethnicity: (Circle one) Hispanic or Latino Not Hispanic or Latino Declined to specify Other

Home Phone: (___) ________________Cell Phone: (___) ____________________

Mailing Address: ____

City: __________________________________ State: __________ Zip: _____________

Patient's Social Security Number: ________-_____-___________

Employer: ____

Primary Insurance: _______________________________ ID#: ___________________

Secondary Insurance: ____________________________ ID#: ___________________

Third Insurance: _________________________________ ID#: ___________________

If your insurance coverage is through a spouse or other family member, you must fill out this section completely:

Subscriber Name: ________________________ **Relationship:** _________________

Subscriber SSN: ________-_____-___________ **DOB**: ____ /____ /_________

Contact Phone: (___) _________________

Employer Name: ____

Insurance Name: __________________________**Policy#:** ______________________

Are you currently staying in a skilled nursing facility? ☐ No ☐ Yes

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Is this a Workers Compensation Injury? ☐ No ☐ Yes-Complete WC Form
Is this an Auto Accident Injury? ☐ No ☐ Yes-Complete Auto Injury Form
Referring Physician: ____
Primary Medical Doctor: ____
In Case of Emergency – Please list the nearest relative/friend we may contact (not living with you.)
Name: _____________________________ Telephone: (___) _____________
Patient Email Address: ____
Preferred method for appointment reminders: ☐Call ☐Email ☐Text

> Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment (if requested), to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. By signing below, I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number, or emails to receive communication as stated above. I understand that the request to receive emails and text messages appointment reminders, will apply to all future appointment reminders unless I request a change in writing.

Insurance Authorization and Assignment and Financial Policies

Our policies regarding billing and payment are detailed below. **We reserve the right to reschedule routine appointments when payment is not available at time of service.**

Insurance Authorization and Assignment: I request that payment of authorized benefits be made either to me or on my behalf to Vitreo-Retinal Medical Group, Inc. (Retinal Consultants Medical Group) or Northern California Advanced Surgery Center LP for any services furnished to me by that physician or Vitreo-Retinal Medical Group, Inc. or Northern California Advanced Surgery Center LP. I authorize any holder of medical information about me released to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, the physician or Vitreo-Retinal Medical Group, Inc. or Northern California Advanced Surgery Center LP agrees to accept the charge determination of the payer as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

Patients with Insurance: We contract with many but not all insurance plans. Please

verify with your insurance carrier if we are contracted with your insurance plan. If you receive treatment from a doctor that is not contracted with your insurance or is considered out-of-network, the insurance may pay at a lower rate or nothing at all. The remaining balance will be your responsibility. You understand that you are responsible for any amounts due as a result of providing false or incorrect insurance information. Your insurance company mandates that we collect co-payments at the time of your visit unless you have enrolled in our Auto Payment Collect Program.

Private Pay Patients: If you do not have insurance, please be prepared to pay for your visit at the time of service. If you are referred to us for an emergency and will not be able to pay for your visit, please ask to speak with our Billing Office at the time of your appointment. If you obtain MediCal coverage with retro-active coverage, you are responsible to notify the Billing Office to bill any now covered services. We will refund any amounts that you previously paid when we receive payment from MediCal.

Deposits and Credit Balances: Deposits paid will be applied to the most recent date of service. Payments will be applied to the oldest date of service. Credits are applied to any outstanding balance. If you are in an active treatment plan, credits may be applied to future balances due. Any remaining credit balance after your treatment plan is complete will be refunded to you. Credit balances on your account may also be applied to outstanding balances at our surgery center, the Northern California Advanced Surgery Center, and visa versa.

Auto Payment Collect Program: We encourage you to enroll in our Auto Payment Collect Program to cover your patient balance. Enrolling in this program places your credit card on file and we will not collect non-drug related funds at time of service. We will charge your credit card after the insurance company has processed your claim and determined what your patient portion is.

Credit Check: We may run a credit check as part of our collection process.

Past Due Accounts: If your account becomes past due and/or you are unable to fulfill any payment plan agreement, please contact our Billing Office to discuss. If your account is sent to collections, we will add 30% to your outstanding balance due to cover the collection fee unless prohibited by your insurance carrier.

I have read and acknowledge the above policies:

____ ________________
Signature of Responsible Party Date

____
Printed Name of Responsible Party

____
Patient Name if Other than Responsible Party