GLAUCOMA PLUS
EYE CARE

PATIENT REGISTRATION

Name: _____
(Last Name) (First Name) (Middle Name)

Sex: ❑ Male ❑ Female Date of Birth: _____ / _____ / _____ SSN: _____
(Month) (Day) (Year)

Address (or PO Box): _____

City: _____ State:_____ Zip:_____

Phone: (H) _____-_____-_____ (C) _____-_____-_____ (W) _____-_____-_____

Contact Preference: ❑ Home ❑ Cell ❑ Work

Email Address: _____

Primary Language Spoken: _____ ❑ Patient Declined

Race(s): ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Patient Declined

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

How did you learn about our practice? ❑ PCP ❑ Other: _____

Primary Care Physician: _____ Phone: _____-_____-_____

Referring Physician: _____ Phone: _____-_____-_____

Other Physician: _____ Phone: _____-_____-_____

Preferred Pharmacy: _____ Address or Phone: _____

Please Initial:

X_____ **Information Regarding Dilating Eye Drops**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops can blur vision for a length of time which varies from person to person and make bright lights bothersome. Driving may be difficult immediately after an examination. We recommend making transportation arrangements for your appointment if you are sensitive to the dilating drops. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Glaucoma Plus Eye Care, LLC physicians and designated assistants to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

X_____ **Consent to Call**

I agree to receive phone calls and voicemails from Glaucoma Plus Eye Care, LLC. Phone calls may be about appointments, test results, and more.

X_____ **Consent to Text**

I agree to receive automated text alerts from Glaucoma Plus Eye Care, LLC on my mobile phone. Text alerts may be about appointments, announcements, and more.

X_____ **Financial Policy & Assignment of Benefits**

I certify that I have read, understand, and agree to the Glaucoma Plus Eye Care, LLC Financial Policy and Assignment of Benefits.

X_____ **Notice of Privacy Practices**

I acknowledge that I have received the Glaucoma Plus Eye Care, LLC Notice of Privacy Practices.

I consent to treatment by the physician(s) and staff of Glaucoma Plus Eye Care, LLC. I consent to the use and disclosure of my protected health information for treatment, payment, or healthcare operations as permitted by HIPPA (Health Insurance Portability and Accountability Act). I certify that the information stated on this form is correct and true to the best of my knowledge. I will not hold the physician(s) and staff of Glaucoma Plus Eye Care, LLC responsible for any errors or omissions I have made in this form.

X_____
(Patient Signature or Signature of Authorized Representative) (Date)

Name of Authorized Representative: _____ Relationship to Patient: _____

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INSURANCE INFORMATION

Primary Insurance: _____

Primary Insurance Policy Holder: ❑ Self ❑ Parent/Guardian ❑ Spouse ❑ Other: _____
Please complete if other than self:

Policy Holder Name: _____
(Last Name) (First Name) (Middle Name)

Policy Holder Date of Birth: _____ / _____ / _____
(Month) (Day) (Year)

Secondary Insurance: _____

Secondary Insurance Policy Holder: ❑ Self ❑ Parent/Guardian ❑ Spouse ❑ Other: _____
Please complete if other than self:

Policy Holder Name: _____
(Last Name) (First Name) (Middle Name)

Policy Holder Date of Birth: _____ / _____ / _____
(Month) (Day) (Year)

Tertiary Insurance: _____

Tertiary Insurance Policy Holder: ❑ Self ❑ Parent/Guardian ❑ Spouse ❑ Other: _____
Please complete if other than self:

Policy Holder Name: _____
(Last Name) (First Name) (Middle Name)

Policy Holder Date of Birth: _____ / _____ / _____
(Month) (Day) (Year)

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FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

FINANCIAL POLICY

INSURANCE: You are responsible for providing all current medical insurance information at the time of your initial visit and providing any changes and/or updates to this information at subsequent visits.

REFERRALS: If your insurance plan requires a referral to be obtained prior to services rendered at a specialist, **it is your responsibility to obtain the referral from your primary care physician and present it during your initial visit in order to be seen by the physician**. Your appointment may be rescheduled if you do not have the required referral. If you inadvertently receive medical care or visits with the physician without a required referral, you will be financially responsible for the visit. If subsequent referrals are required, it remains your responsibility to obtain and present the referral at each applicable visit.

CO-PAYMENTS: If your insurance requires a co-payment, it will be due at the time of service. Any increases to co-payments will be reported by your insurance after your claim is processed and the difference will be your responsibility. Your co-payment will be collected prior to seeing the physician. We accept cash, checks, Apple Pay, and credit cards (Visa, Mastercard, American Express, and Discover) for payment.

NO INSURANCE: If you do not have health insurance coverage, payment in full is required at the time of service.

BILLING: Insurance claims will be filed on your behalf; however, **you are financially responsible for paying any deductibles, co-insurance, and co-payments as reported by your insurance**. Your insurance plan may not cover all services, even though your physician determines the service(s) to be medically necessary. Examples of non-covered services include but are not limited to treatment or tests. Any charges not covered by your insurance will also be your responsibility. Payment is due upon receipt of billing statement. If your account goes into collection, additional fees for collection agency, attorney fees, and/or court cost will be added to the outstanding balance on your account.

APPOINTMENT CANCELLATIONS: 24 hour advanced notice is required for appointment cancellations or rescheduling. Failure to provide 24 hour notice may result in a $25 charge.

ASSIGNMENT OF BENEFITS

I understand that insurance is a means of reimbursement and not a substitution for payment. I authorize Glaucoma Plus Eye Care, LLC to file my healthcare claims on my behalf for medical services rendered. I certify that the information I have reported with the regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for the processing of my claims to my insurance(s), in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration. I authorize payment of medical insurance and benefits which are payable to me under the terms of my insurance to be paid directly to Glaucoma Plus Eye Care, LLC for services rendered. I agree to pay all copayments, coinsurance, deductibles, out-of-pocket expenses, and non-covered services as determined by my insurance plan at the time of service. I understand and agree that I am ultimately responsible for payment of all fees for services rendered regardless of my insurance status. A copy of this authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at anytime in writing. I understand and agree that I am financially responsible for charges not paid by my insurance company.

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NOTICE OF PRIVACY POLICY

Summary Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this is a brief summary of your privacy rights and the privacy practices of Glaucoma Plus Eye Care. Please also read our Full Notice of Privacy Practices for a full description of our practices and of your rights (available upon request at our office). Please review this notice carefully.

Glaucoma Plus Eye Care, along with your Primary Care Physician, Referring Physician, and all other Physicians/facilities who participate in your care are allowed to share medical information with each other as part of an organized health care arrangement for treatment, payment and operational activities. We will use this information in order to provide our patients complete and comprehensive health care services. If you have any questions with either our Summary or Full Notice of Privacy Practices, please contact our office at (410)715-2212.

Our Commitment

We are committed to protecting your Private Health Information. As health care providers, Glaucoma Plus Eye Care is required by law to keep health information about you private, to give you our notice about our privacy practices and to follow the practices outlines in our Full Privacy Notice.

How We May Use and Disclose Your Information

We may use your Private Health Information for treatment, payment, and health care operations. Under certain circumstances, Glaucoma Plus Eye Care may also disclose your Private Health Information for other purposes without your written permission. We may give out information about you for public health purposes; to report abuse, neglect, or domestic violence, for health oversight audits or inspections, for certain approved research purposes, for funeral arrangements or organ donations, to government programs, to worker's compensation, and in emergency situations. We may also disclose health information when we are required by law, such as in response to a request from law enforcement or in response to a court order. We may also contact you for appointment reminders and to tell you about possible treatment options and health services. In addition, we may also disclose health information about you to your family, relatives, friends, or caregivers who may be involved in your care for treatment and payment purposes.

Your Rights Concerning Your Health Information

You may ask to review or receive copies of your health information. There may be a fee for this service. You may ask us to amend health information in your medical or billing records you believe is incorrect or incomplete. You may request an accounting of certain disclosures we have made from your medical records. You may request alternate forms of communication. You may ask us to restrict how we use or disclose your Private Health Information. You may complain to us and the federal government if you believe your privacy rights have been violated. You have a right to a paper copy of our current Full Privacy Notice. We will consider your request, but we may not agree if we are not required by law to do so.

We reserve the right to make changes to this Summary Notice and will provide a copy of the current Full Privacy Notice at the location where treatment is provided upon request.