

RETINA & VITREOUS CONSULTANTS

PATIENT INFORMATION

Last Name _____ FirstName _____ Middle _____

Address _____

City _____ State _____ ZIP _____ Home Phone (____) _____

Marital Status: Single Married Divorced Widowed Other

Sex: Male Female Date of Birth: _____ Age: _____

Social Security # _____ - _____ - _____

Patient's Employer: _____ **Retired**

Occupation: _____ Work Phone _____

Referring Ophthalmologist/Optomtrist: _____ Phone _____

Primary Care/Family Doctor: _____ Phone _____

Diabetic: Non-Insulin Insulin Non-Diabetic

WORKERS COMP INFORMATION

Will this be covered under Workers Comp? Yes No

If Yes, Company Name: _____ Phone _____

Company Address _____ City/St/Zip _____

Treatment Authorized by _____ Accident Date _____

EMERGENCY CONTACT

Nearest Friend or Relative **NOT** living in the same household

Name _____ Phone _____

Relationship to Patient _____

RESPONSIBLE PARTY

(if different from previous page)

Last Name _____ FirstName _____ Middle _____

Address _____

City _____ State _____ ZIP _____ Home Phone (____) _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____

Policy Number _____

Subscriber Name _____ Sex: Male Female

Subscriber Date of Birth _____

Subscriber Social Security # _____

How are you related to the Policy Holder:

Self Spouse Mother Father Other

Employment Status: Retired Employed

(If employed please fill out all of the employment information)

Subscriber's Employer Name _____

Employer's Address _____

City _____ State _____ Zip _____ Work Phone _____

Does this Policy require a Referral? Yes No Unknown

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Policy Number _____

Subscriber Name _____ Sex: Male Female

Subscriber Date of Birth _____

Subscriber Social Security # _____

How are you related to the Policy Holder:

Self Spouse Mother Father Other

Employment Status: Retired Employed

(If employed please fill out all of the employment information)

Subscriber's Employer Name _____

Employer's Address _____

City _____ State _____ Zip _____ Work Phone _____

Does this Policy require a Referral? Yes No Unknown

TO OUR PATIENTS:

Retina & Vitreous Consultants of Wisconsin accept assignment as participating providers in the Medicare Program. We will file claims to your primary and secondary insurance for you, if you provide us with that information. Please feel free to speak with someone in the business office if you have further questions regarding our billing practices.

PATIENT AUTHORIZATION:

1. **RELEASE OF INFORMATION:** I hereby give my consent to Retina & Vitreous Consultants of Wisconsin to release any information regarding my care and treatment as may be required by any insurance carrier in connection with payment by the insurance carrier of any portion of my bill.

2. **RELEASE OF MEDICAL RECORDS:** I hereby give my consent to Retina & Vitreous Consultants of Wisconsin to release duplicate or fax copies of medical Records regarding my care and treatment to authorized Doctors, Clinics, Myself, or Persons I Deem to receive such records. I understand this may be revoked at any time by providing my written revocation. I understand that I have the right to review Retina & Vitreous Consultants of Wisconsin’s **NOTICE OF PRIVACY PRACTICES**, which describes how medical information about me may be used and disclosed, and acknowledge receiving a copy of the Notice from Retina & Vitreous Consultants of Wisconsin with this packet unless I have received a copy of it previously.

3. **RESPONSIBILITY FOR PAYMENT/PATIENT AGREEMENT:** I understand that the physician(s) practicing under the name of Retina & Vitreous Consultants of Wisconsin are in no way bound by fee schedules or other guidelines published by any insurance company, government agency, etc. I agree to pay any portion of the fees charged to me that are not covered by my insurance company in the event full coverage is not afforded me or if I do not have the necessary coverage.

4. **ASSIGNMENT OF BENEFITS:** I hereby authorize payment to be rendered directly to Retina & Vitreous Consultants of Wisconsin for the benefits otherwise payable to me by any third party.

Patient, Guardian or POA Signature

Date

Front Desk: Please input the following:	
Patient Name: _____	Chart Number: _____
Reviewed by: _____	

RETINA & VITREOUS CONSULTANTS
Additional Release(s) of Medical Information and
Medical Records to Designated Persons.

In addition to the above consents for release of information, I authorize Retina & Vitreous Consultants of Wisconsin to release records and information regarding my health to the designated person(s) listed below. I understand the additional release(s) may be revoked at any time by providing my written revocation.

Person To Release to: _____
Name Relationship (optional)

Address: _____
Street Address City State Zip

Type of Information to be released: (Check All That Apply)

Medical History Lab Reports Surgical Reports Test Results
 Doctor's notes Billing/Statement Information All

This authorization expires on ___/___/___ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Person to Release To: _____
Name Relationship (optional)

Address: _____
Street Address City State Zip

Type of Information to be released: (Check All That Apply)

Medical History Lab Reports Surgical Reports Test Results
 Doctor's notes Billing/Statement Information All

This authorization expires on ___/___/___ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Signature of Patient, Legal Guardian or Power of Attorney Date

You may request additional release(s) of medical information and medical records forms from the front desk.

Witnessed by: _____