MISSOURI RETINA
CONSULTANTS, PC

WELCOME TO MISSOURI RETINA CONSULTANTS, PC

We look forward to seeing you at your visit and partnering with you to obtain the best care for your retinal problems. Your appointment will begin with initial screening by a technician. We usually dilate both eyes which requires a period of time before seeing the physician. Your appointment may take up to two hours, especially the first visit.

Please Bring with You:

- ❑ A current list and/or bottles of all eye drops
- ❑ A current list of all medications
- ❑ Name and contact info for your medical physician and eye doctors
- ❑ Health Insurance card and co-pay if required
- ❑ Picture identification such as a driver's license
- ❑ Address and phone number of your pharmacy
- ❑ Pre-completed forms in this packet-if possible, fax them to 573-777-8739 or mail them to our office before your appointment.
- ❑ A driver (as both eyes will be dilated)

For Your Safety:

Each individual reacts differently to the dilation process. Some patients require assistance with ambulation after dilation to prevent falls. Therefore, it is advisable to bring a family member or someone to assist you. Furthermore, we do not recommend driving after dilation.

We kindly ask all patients to arrive 15 minutes prior to your appointment time.

MISSOURI RETINA
CONSULTANTS, PC

REGISTRATION FORM

Please Print Clearly

Name: ____________________

Address: ____________________

City: __________ State: ____ Zip: ________

Home Phone: ____________________

Cell Phone: ____________________

Preferred Contact Method?

❑ Home Phone ❑ Cell Phone ❑ Email

Social Security Number: ____________________

Date of Birth: __________ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Other: __________

Preferred Language: ____________________

Referred By: ____________________

Primary Care Doctor: ____________________

Parent/Spouse: ____________________

If Patient is a Minor, Authorized By: __________

Signature: ____________________

Employer: ____________________

Work Phone: ____________________ Ext: ______

Email Address: ____________________

In Case of Emergency Notify: ____________________

Relationship: ____________________

Emergency Phone: ____________________

INSURANCE

Primary Insurance: ____________________

Name on Insurance Card: ____________________

Insured's Date of Birth: ____________________

Relation to Patient: ____________________

Policy #: __________ Group #: __________

Secondary Insurance: ____________________

Name on Insurance Card: ____________________

Insured's Date of Birth: ____________________

Relation to Patient: ____________________

Policy #: __________ Group #: __________

PLEASE READ AND SIGN BELOW

I authorize Missouri Retina Consultants, PC to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed during any and all visits. I authorize payment of insurance benefits directly to the physician and acknowledge that I am financially responsible for ALL charges for services rendered to me by Missouri Retina Consultants, PC. I further acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Patient: ____________________ Date: __________

Responsible Party Signature: ____________________ Relationship to Patient: ____________________

MISSOURI RETINA
CONSULTANTS, PC

MEDICAL HISTORY FORM

Please Print Clearly

Patient Name ______________________ Date of Birth ______________

List of Significant Past Surgeries Including Eye Surgeries ______________________

____

Food or Drug Allergies ______________________

Alcohol Use? ______________________ Tobacco Use? ______________

Do You Have Any History Of (Check Which Applies)

Heart Disease ❑ YES ❑ NO

Irregular Rhythm
(A-fib, Pacemaker, AICD) ❑ YES ❑ NO ❑ N/A

Length of Time on
Medication for
Hypertension/ HBP ______________

Blood Disorders ❑ YES ❑ NO

Stroke ❑ YES ❑ NO

Diabetes ❑ YES ❑ NO

If Yes, Duration ______________

Insulin Dependent ❑ YES ❑ NO

Endocrinologist ______________

Result of Last
HbAIC ______________

Date ______________

Cancer ❑ YES ❑ NO If Yes, Specify ______________

HIV or Other
Infectious Diseases ❑ YES ❑ NO If Yes, Specify ______________

Other ______________________

Family History (Please List Relationship. i.e. - Father, Mother, etc.)

Blindness ______________ Macular Degeneration ______________

Diabetes ______________ Glaucoma ______________

Retinal Detachment ______________ Other ______________

Signature of Patient/ Guardian or POA: ______________________ Date: ______________

PLEASE LIST YOUR CURRENT MEDICATIONS ON THE BACK OF THIS FORM

OR BRING A LIST TO YOUR APPOINTMENT.

MISSOURI RETINA
CONSULTANTS, PC

HOME MEDICATION LIST

Please Print Clearly

Medication Name	Dose	Frequency	Reason Taken

105 N. Keene St., Ste. 102, Columbia, MO 65201 | phone.573.777.8738 | fax.573.777.8739 | MissouriRetina.com

MISSOURI RETINA
CONSULTANTS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Health Information Privacy Practices, which provides a complete description of health information uses and disclosures. I understand that I have the following rights and privileges.

The right to review the notice prior to signing this consent. A copy is available upon request.

The right to object to the use of my health information for directory purposes.

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, Missouri Retina Consultants will no longer use or disclose medical information about me for the reasons covered by my written authorization. I understand that Missouri Retina Consultants is unable to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me.

I further understand that if I choose to revoke my consent, Missouri Retina Consultants may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

By signing this document, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices.

Print Name____

Signature____ Date__________________

I authorize Missouri Retina Consultants to release my protected health information to the following family member or other person involved in my care or payment for my care.

Name: _________________________ Relationship: ___________ Phone Number: _____________

Name: _________________________ Relationship: ___________ Phone Number: _____________

Name: _________________________ Relationship: ___________ Phone Number: _____________

MISSOURI RETINA
CONSULTANTS, PC

AUTHORIZATION OF BENEFITS

Please read carefully and sign on the signature line below:

I hereby authorize Missouri Retina Consultants, PC to release necessary information to insurance carriers for the processing of my medical claim and to referring physicians.

I hereby authorize my insurance company(s) to make direct payment to Missouri Retina Consultants, PC for medical benefits. I hereby acknowledge that I accept all legal financial responsibility for all charges incurred. I agree to forward all insurance reimbursements directly to Missouri Retina Consultants, PC upon receipt from my insurance carrier. I understand that I am responsible for all charges whether or not paid by my insurance including collection and legal fees associated with collection of any balance. If my account becomes delinquent requiring collective action, a fee of 25% of the total balance will be added to my account. I have read these terms and assume responsibility for paying any charges accordingly.

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration or its agents any information needed for this or related Medicare claim.

I understand that if I do not have insurance or if Missouri Retina Consultants, PC is not a participating provider of my insurance, payment will be required at the time of my visit. Please see the Payment Policy on the reverse side of this form.

Date ______________ Signature ______________________________

MISSOURI RETINA
CONSULTANTS, PC

PAYMENT POLICY

When you visit our office you will be asked for your insurance cards at every visit. We accept all major credit cards and checks.

COPAYS:
You are expected to pay your copay at the time of service.

OUT OF POCKET AND/OR HIGH DEDUCTIBLE HEALTH PLANS:
If your out-of-pocket or deductible is not met, you will be expected to pay for charges in full up to the amount of your out-of-pocket or deductible expense at the time of service. If you are unable to pay the full amount, you will be required to place a credit card on file and be required to pay a deposit of $300 before being seen. If your balance exceeds $300, we are willing to accept a reasonable payment plan.

UNINSURED PATIENTS:
Missouri Retina Consultants, PC will offer discounted Physician fees to those without insurance. However, we require payment in full at the time of service and require a deposit of $300 before services are rendered.

If you require surgery or other procedures, you will be required to pay the charges in full prior to the procedure. If the surgery is performed at an outside institution, there will be additional charges for their services that are not covered by this policy and are negotiated and billed separately by that facility.

INJECTIONS:
If you are insured and have a covered indication you should be covered, however, you may still have out-of-pocket expenses depending on your insurance benefits, deductibles, etc. You may qualify for a drug assistance program.

If you are uninsured or the diagnosis is not covered, you will be expected to pay for the cost of the drug at the time of service.

NO-SHOWS & CANCELLATIONS:
If you need to cancel or reschedule an appointment, you must provide no less than 24 hours' notice prior to the scheduled appointment time. This courtesy makes it possible to provide your reserved time to another patient. If you fail to provide such notice, our practice may bill you a fee per missed appointment. These charges are your responsibility and billed directly to you. Any such charges must be paid in full before your next appointment. Please help us to serve you better by keeping your regularly scheduled appointment. If you fail to present to your appointments three or more times, you may face dismissal from the practice.

If you have any questions, please ask the Front Desk Staff or call our Insurance Office for further information.