Retinal Consultants of San Antonio

Disease and Surgery of the Retina and Vitreous

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PATIENT REGISTRATION

Date:______________________ **Email**:___________________________________

Patient Name: ___________________________________ **DOB**:_________________

Address:________________________________ **Apt#**_______ **Male** ☐ **Female** ☐

City:_________________ **State**:______ **Zip**:_________ **SSN#**__________________

Home Ph#___________________ **Cell#**__________________ **Work#**_________________

Occupation:_____________________________ **Employer/School**: ___________________

In case of emergency contact ______________________ **Phone #** ____________________

Single ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Child** ☐

INSURANCE INFORMATION

Policy holders Name:________________________ **Relationship to Patient**:____________

Primary Insurance:______________________ **Policy holders SSN#** __________________

Secondary Insurance:______________________ **Policy holders DOB**: _______________

Workman's Comp Ins ☐ **DARS** ☐ **Counselor's name** ________________________

Who may we thank for REFERRING you to our clinic:__________________________

I am responsible for paying any deductible, co-insurance or balance not paid for by my insurance(s). I understand that I am financially responsible for all charges today and for all future appointments and or treatments whether or not paid by said insurance(s). I hereby authorize said assignee to release all information necessary to secure payment. This will remain in effect until revoked by me in writing.

Patient's Signature__________________________________

(Parent signature if patient is a minor)

RETINAL CONSULTANTS OF SAN ANTONIO
PATIENT PRIVACY PRACTICES CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Retinal Consultants of San Antonio provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Health information may be disclosed for treatment, payment or heath care operations.
- Health information may be disclosed to family members, friends, or persons accompanying the patient in the exam room.
- Retinal Consultants of San Antonio has a Notice of Privacy Practices that I (the patient) have had the opportunity to review.
- Retinal Consultants of San Antonio reserves the right to change the Notice of Privacy Policies.
- As a patient you have the right to restrict the use of your health information, but Retinal Consultants of San Antonio does not have to agree to those restrictions.
- As a patient you may revoke this consent in writing at any time. Future disclosures will then cease.
- Retinal Consultants of San Antonio may condition treatment upon receiving this consent.

I authorize the disclosure of my **health information with** individuals named here:

______________________________	______________________________
Name	Relationship to Patient
______________________________	______________________________
Name	Relationship to Patient

I acknowledge and consent to the above stated:

______________________________	______________________________
Patients Name printed	Patient or Representatives Signature

Signing Representatives relationship to Patient: ______________________________

Witness: ______________________________ Date: ______________________
Printed name – Practice Representative

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