RetinaMacula
SPECIALISTS

PATIENT REGISTRATION FORM

TODAY'S DATE:_____

PERSONAL INFORMATION

Name:_____

Address:_____

City, ST, Zip_____

Birth Date_____Age_____

Language: English / Spanish /Other

Other:_____

Ethnicity: Hispanic or Latino / Non Hispanic

Social Security#_____

Home Phone#_____

Cell# / Other_____

Driver's License#_____

Driver's License State_____

Email Address:_____

Employer:_____

Address:_____

City, ST, Zip:_____

Work#_____

Circle: **Married** **Single** **Divorced** **Widowed**

If Married, Spouse name:

_____

Referred by:_____

Primary Physician:_____

Primary Physician#:_____

INSURANCE INFORMATION

Insurance Carrier: _____

Policy#_____

Group#_____

If policy holder is someone other than you:

Name:_____

Social Security#_____

Date of Birth_____

SECONDARY INSURANCE

Insurance Carrier:_____

Policy#_____

Group#_____

PHARMACY INFORMATION

Pharmacy_____

Address:_____

City, ST, Zip

EMERGENCY CONTACT INFORMATION

Name:_____Relationship_____Phone#_____

Retina Macula Specialists, PLLC

INSURANCE SIGNATURE AUTHORIZATION

I understand that Dr. Jaime Membreno may provide services and/or devices that he deems necessary for my care/treatment which my insurance may not cover. Dr. Jaime Membreno's decision is a professional one made in my best interest and is not dictated by any governing agency. To this end, I hereby authorize and accept fill responsibility for the charges associated with such services and/or devices. I authorize Retina Macula Specialists, PLLC to use this signature as a release to the Social Security Administration, its intermediaries, carriers and/or to the billing agent of this physician or supplier of any information needed for this or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit either to myself or the party who accepted assignment. I may revoke this authorization by notifying Retina Macula Specialists, PLLC in writing.

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any medical records which may be requested by my insurance company for the purpose of processing and insurance claim. A copy of this authorization may be used in lieu of the original. I further authorize release to any subsequent treating physician any medical information and/or records concerning diagnosis and treatment.

PAYMENT SIGNATURE AUTHORIZATION

I hereby authorize payment by my insurance company to Dr. Membreno, directly. I understand that any payment received over and above my indebtedness will be refunded to me when my bill is paid inf full and that I am financially responsible for charges not covered under this authorization. I understand that I am legally responsible for the payment of charges of services. Furthermore, I understand that payment for charges not covered contractually by insurance are due at the time of service. I have read, understand, and agree Retina Macula Specialists, PLLC financial policy. I permit a copy of these authorization and assignments to be used in place of this original.

_____ _____

Signature of Patient or Legally authorized individual Date

INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get better view of the inside of the eye. Dilating drops frequently blur vision for a length which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Jaime Membremo, MD and/or such assistants as my be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

PHOTO/VIDEO/AUDIO RECORDING

Unless express permission is giving photo, audio and visual recordings are not permitted during your visit.

_____ _____

Signature of Patient or Legally authorized individual Date

RETINA MACULA SPECIALISTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information(PHI), I understand that this information can and will be used to:

- Conduct, plan and direct any treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (insurance companies)
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I may request a copy of your *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice pf Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing (RMS) restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand RMS is not required to agree to my requested restrictions, but if RMS does agree then RMS is bound to abide by them.

For patients who bring companions for their appointment: I understand that my private health information may be discussed at any time during any interaction between myself and the RMS staff. If I allow my companions to be present during such interactions, my companions may be private information. It is MY responsibility to exclude my companions from such conversations between myself and RMS staff if I do not wish my companions to be exposed to my private information.

Patient Name(print):_____

Signature:_____

Date:_____

I authorize RMS staff to leave messages pertaining to my appointments by the following methods and assume responsibility to notify them whenever this information changes: (RMS staff will not leave messages containing private medical information)

Home Phone/answering machine	_____Yes	___No
Work phone/voicemail:	_____Yes	___No
Cell/Phone/voicemail:	_____Yes	___No

I authorize access to my protected health information for the following persons(optionally):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Name: _____ DOB: _____

MEDICATION	DOSAGE

RetinaMacula
SPECIALISTS

Assumption of the Risk Waiver of Liability Relating to Coronavirus/COVID-19

I acknowledge the contagious nature of the coronavirus/COVID-19 and that many public health authorities still recommend practicing social distancing.

I further acknowledge *Retina Macula Specialists(the "Practice")* has put in place preventative measures to reduce the spread of the coronavirus/COVID-19.

I further acknowledge that the Practice cannot guarantee that I will not become infected with the coronavirus/COVID-19 and that receiving services from the Practice could increase my risk.

I voluntarily seek services from the Practice and assume the risk that I or my family may be exposed to or infected by coronavirus/COVID-19 by visiting the Practice and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by coronavirus/COVID-19 at the Practice may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Practice staff, and other Practice clients and their families.

I attest that:

- I am not experiencing any symptoms of illness such as a fever, cough, or shortness of breath.

- I have not traveled internationally in the past 14 days.

- I have not traveled to a highly-impacted area within the United States in the past 14 days.

- I do not believe that I have been exposed to a person with a confirmed or suspected case of COVID-19.

- I have not been diagnosed with COVID-19 and not yet cleared as non contagious by states or local public health authorities.

- I am following recommended guidelines as much as possible – practicing social distancing and otherwise limiting my exposure to the coronavirus.

I hereby release, discharge and agree to indemnify and hold the Practice harmless from, and waive on behalf of myself and my heirs and personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the Practice, or that may otherwise arise in any way in connection with any services received from the Practice. I understand that this release discharges the Practice from any liability or claim that I or my heirs, personal representatives may have against the Practice with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from or in connection any services received from the Practice. This liability waiver and release extends to the Practice together with all of its owners, officers, directors, affiliates, employees and agents.

Print Name Signature Date

! PATIENT FORMS !

We do not fill out patient forms i.e patient disability forms, workers compensation, FMLA etc.

Print Name Signature Date