PATIENT FINANCIAL POLICY

Thank you for choosing Carolina Retina Institute for your eye care needs. Our first priority is our patients' well-being. In order for us to provide you with the best possible care, we would appreciate your help by understanding your responsibility as it relates to our financial policy. The following is our financial policy.

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT THE TIME OF SERVICE

Health insurance and payment:

Your health insurance is a contract that you sign with the insurance company. We are not part of this contract. We will submit a claim to your insurance company for your visit as a service to you. However today's visit charges are your responsibility.

It is also your responsibility to ensure that we are a participant in your insurance. You should be aware of your benefits coverage and make sure that we have the required pre approval and/or referral for your visits. If the service provided is a non-covered service, you will be responsible for 100% of the bill.

Billing Information:

We must have your current billing information on file at the time of each visit. Please let us know if your insurance coverage or your address has changed since your last visit. We need this information to properly bill your insurance company. If the payment is denied because of incorrect billing information, you will be responsible for the entire bill.

Insurance Participation and Payments:

For all insurances in which we are a participating provider, we are required to collect all co-pays, deductible, and /or co-insurances at the time of treatment. In case we are not a participating provider, you will be responsible for the entire bill. In this case, we will provide you with a statement that you can submit to your insurance company to get reimbursed

(Contd.....)

Appointment Policy:

Due to the increasing number of cancellations and no-show appointments, starting March 1, 2019, we will start enforcing our No Show fee of $25 for appointments that are missed or cancelled less than 24 hours prior to your appointment. Please notify us right away at 919-859-4511 if you are unable to keep your appointment. Please help us serve your Eye Care needs more efficiently by keeping your scheduled appointments. _____ _____

Signature **Date**

Past Due Balances:

If you do not receive an explanation of benefits (EOB) within 45 days of your visit, please contact your insurance company to ensure that a payment has been made. Balances 60 days past due become your responsibility and you will be expected to make payment arrangements. Any past due balances will be turned over to collection agency after 90 days. In case the balance remains unpaid and any litigation ensues, you will be responsible for our court and attorney fees.

Thank you for understanding our financial policy. If you have any questions, please let us know and one of our representatives will be happy to assist you.

I have read the financial policy. I have been given the opportunity to ask questions. I agree with the financial policy as stated above.

_____ _____

Signature of the Patient or Responsible Party **Date**

CAROLINA RETINA INSTITUTE

AMIT KUMAR, MD

REGISTRATION FORM

First Name _____ **Initial** _____ **Last Name** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

E-mail _____ **SSN** _____ **D.O.B.** _____ **Gender** _____

Home Phone # _____ **Cell Phone #** _____ **Preferred Contact Method** ☐ Home ☐ Cell

Ethnicity ☐ Hispanic/ Latino ☐ Non Hispanic/ Latino **Race:** ☐White ☐African American ☐American Indian ☐Native Hawaiian ☐Asian ☐Hispanic ☐Other

Marital Status _____ **Preferred Language** _____ **How did you hear about us?** _____

Occupation _____ **Employer** _____

Emergency Contact Name _____ **Phone #** _____ **Relationship to Patient** _____

Preferred Pharmacy _____ **Phone #** _____ **Address** _____

Referring Physician _____ **Phone #** _____

Primary Care Physician _____ **Phone #** _____

Optometrist/Ophthalmologist _____ **Phone #** _____

Primary Insurance _____ **Primary Insured Name** _____

Subscriber's SSN _____ **D.O.B.** _____ **Relationship to Patient** _____

Address(If Different) _____ **City** _____ **State** _____ **Zip Code** _____

Secondary Insurance _____ **Secondary Insured Name** _____

Subscriber's SSN _____ **D.O.B.** _____ **Relationship to Patient** _____

Address(If Different) _____ **City** _____ **State** _____ **Zip Code** _____

ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize Carolina Retina Institute, PC(CRI) to release any information about me to Health Care Financing Administration and its agents or any other carrier, necessary to process payments for medical services provided. I request that authorized Medicare or other Insurance payments be made directly to CRI on my behalf for any services provided by staff of CRI.. By signing and submitting the form, I agree that I have read these terms and agree with them.

Signature _____ **Today's Date** _____

CAROLINA RETINA INSTITUTE

AMIT KUMAR, MD

Name _____ **D.O.B.** _____ **Today's Date** _____

Are you Allergic to any Medicines? YES NO If Yes please list here:

Reason for Today's Visit (Required): _____

Medical and Family History : Please check the appropriate box for yourself (S) or your family member (F):

S	F		S	F		S	F	
		Anemia			High Blood Pressure			Stroke
		Arthritis			Heart Attack			Sarcoidosis
		Asthma			Hepatitis			Thyroid Disease
		Cancer (where:_____)			Kidney Disease			Other:
		Diabetes (# of years:_____)			Lupus			Other:

Medications:

Prior Surgeries, Injuries, and/or Hospitalizations: (please list approximate dates)

Social History: (Please circle your answer and provide detail)

Have you ever smoked? Yes No Detail:_____

Do you drink alcohol? Yes No Detail:_____

Do you use recreational drugs? Yes No Detail:_____

Name	D.O.B.	Today's Date

Review of Systems: (If you are having of the following, please circle and provide some detail)

Eyes: Previous Surgery, Contact Lens, Pain, Double Vision, Glaucoma, Cataracts, Macular Degeneration, Dry Eyes, Floaters/Flashes, Retina Issues, Diabetic Retinopathy	☐ None
Ears, Nose, and Throat: Hard of Hearing, Ringing in Ears, Vertigo	☐ None
Cardiovascular (heart/vessels): Chest pain, Dizziness, Fainting Spells, Shortness of Breath, Irregular Heart Beat, Difficulty Lying Flat, Heart Disease, Angina	☐ None
Constitutional: Fatigue/Weakness, Fever, Weight Gain/Loss	☐ None
Respiratory: Wheezing, cough(productive/blood), asthma, difficulty breathing, other	☐ None
Gastrointestinal (Stomach/intestines): Heartburn, Nausea/Vomiting, Jaundice/Hepatitis, Stomach Ulcers	☐ None
Genitourinary (Kidneys/bladder/genitals): Pain/Difficulty, Blood in Urine, History of Kidney Stones, History of STDs, Kidney Disease, Bladder Issues	☐ None
Psychiatric: Anxiety/Depression, Mood Swings, Difficulty Sleeping	☐ None
Endocrine: Increased Thirst, Increased Hunger, Increased Urination, Increased Sweating, Fingernail Changes	☐ None
Blood/Lymph Nodes: Easy Bruising, Gums Bleed Easily, Prolonged Bleeding, Heavy Aspirin Use	☐ None
Musculoskeletal: Stiffness, Arthritis, Joint Pain/Swelling, Unexplained Weight Loss	☐ None
Skin: Rash/Sores, Lesions, Hives/Eczema, Rosacea	☐ None
Neurological: Seizures, Weakness/Paralysis, Numbness, Tremors, Headaches, Jaw Pain	☐ None
Allergy/Immunology: Hives, Itching, Runny Nose, Sinus Pressure	☐ None

Other:

This form completed by **Patient** **Family** **Friend** **Staff**

History reviewed by:_____ **Date:**_____

CAROLINA RETINA INSTITUTE
AMIT KUMAR, MD

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my permission for **Carolina Retina Institute, PC:**

To use and disclose protected health information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO) (**Carolina Retina Institute, PC** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Carolina Retina Institute, PC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Carolina Retina Institute, PC** Privacy Officer 940 SE CARY PARKWAY, SUITE 100, CARY, NC 27518

With this consent, **Carolina Retina Institute, PC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Carolina Retina Institute, PC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **Carolina Retina Institute, PC**, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to **Carolina Retina Institute, PC**'s use and disclosure of my PHI carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Carolina Retina Institute, PC** may decline to provide treatment to me.

A copy of **Carolina Retina Institute, PC**'s privacy notice is posted and at my disposal should I want to review it. I may also request a copy of this form to keep for my records at anytime.

Signature _____ **Today's Date** _____

Patient's Name _____

CAROLINA RETINA INSTITUTE

AMIT KUMAR, MD

PERMISSION TO DISCUSS PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Please initial all that apply:

_____ Please do not release any healthcare information on my behalf

_____ I hereby give my permission to have my appointment/medical information left on my voicemail

_____ I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient / Guardian **Date**

In order to obtain information by telephone, the party calling the practice must share the patient passcode with the staff.

Patient Passcode: _____