CAROLINA RETINA INSTITUTE
AMIT KUMAR, MD

First Name _____Initial ____Last Name _____

Address _____ City _____ State _____ Zipcode _____

Email _____ SSN _____ DOB _____Gender _____

Home Phone # _____ Cell Phone _____

Ethnicity _____Hispanic/Latino or _____Non-Hispanic Latino

Race ____white ____African American ___American Indian ____ Native Indian ___ Native Hawaiian ___

_____Asian ____ Hispanic ____Other

Emergency Contact Name _____ Phone # _____ Relationship to Patient _____

How did you Hear About us ? _____

If searched on google, what keywords did you search for: _____

Referring Physician _____Practice Name _____

Primacy Cary Physician _____ Practice Name _____

Optometrist/Ophthalmologist _____Practice Name _____

Primary Insurance_____ Primacy Insured's Name _____

Primary Insured DOB _____ Relationship to Patient_____

Address (If different) _____

Secondary Insurance _____ Secondary Insured's Name _____

Primary Insured's DOB _____ Relationship to Patient _____

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 _____ **DOB** _____

Reason for Today's Visit Reequired)_____

Are you Allergic to any Medications? Yes No. If Yes Please List Here _____

_____

Preferred Pharmacy _____ **Phone #** _____

Address _____

Patient's Medical History: Please check the appropriate box for yourself:

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

Family History: Does Anyone in your family has the following illness, If yes, WHOM ?

- **Blindness Relationship:** _____
- **Retinal Detachment Relationship:**_____
- **Macular Degeneration Relationship:**_____
- **Glaucoma Relationship:**_____
- **Diabetes Relationship:**_____
- **Cancer Relationship:**_____
- **Stroke Relationship:**_____
- **Heart Disease Relationship:**_____

Patient Medications:

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

Name _____ **DOB** _____

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, and 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

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 _____

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

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

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 any time. 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 any time.

Signature _____ Today's Date _____

Patient's Name _____

CAROLINA RETINA INSTITUTE
AMIT KUMAR, MD

PATIENT FINANCIAL POLICY

Thank you for choosing Carolina Retina Institute. We are committed to providing you with the highest quality medical eye care possible in an efficient and cost-effective manner. In order to service your insurance needs, we require your understanding of our office financial policy.

We will file your medical claims as a courtesy, to all insurance companies we are contracted with. Although we make every effort to verify your coverage we cannot guarantee the information given to us by your insurance company is correct. If we are given incorrect insurance information either by the patient or an insurance company that delays payment beyond the limit to file the claim, you will be responsible for the charges.

Patient Responsibilities

- At each visit, it is the patient's responsibility to provide your current and correct medical insurance information. You will be asked to show your current insurance card(s) and driver's license.
- You will notify a receptionist of any demographic changes such as address and phone number.
- Patients are responsible for understanding their own coverage, co-pays, deductibles, referrals or other insurance requirements.
- If your plan requires a referral to see a specialist, you must ensure the proper referral is in place prior to your appointment. Failure to obtain a referral will result in you being financially responsible for all services rendered which must be paid at the time of service.
- Your total responsibility is expected at the time of your visit unless prior arrangements have been made.
- Upon processing of your claim(s) through insurance(s) on file, any remaining balances will be reflected in a statement mailed to you.
- In the event of a claim denial. Unrelated to billing errors, you may be asked to contact your insurance company to assist in denial resolution. Patient assumes full responsibility of payment if you fail to comply with the assistance request.

Patient Assistance Programs

We often enroll qualified patients in the grants and assistance programs to help pay for the cost of injectable drugs. These programs often have a copay amount similar to insurance copays. You are responsible for paying this copay on days you receive an injection in addition to insurance copays. Also note these programs open and close at will. If the foundation runs out of funds, you will be responsible for any unpaid drug coinsurances.

Authorization to Release Information

I authorize release of my medical information, pursuant to the applicable federal and state laws, rules and regulations, to third party payers and other providers participation in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Carolina Retina Institute any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on consent.

Assignment of Benefits

I hereby request that payment of authorized medical, Medicaid and all other insurance benefits be made on my behalf to Carolina Retina Institute for any services provided to me. I authorize any holder of medical information about me to release to the appropriate entity and its agents and information needed to determine these benefits payable for related services.

Guarantee of Payment

If my insurance has a contract with Carolina Retina Institute I am not responsible for amounts the practice has agreed to write-off per the contract. If my insurance does not have a contract with Carolina Retina Institute I agree to be responsible for any amount paid by my insurance plan. In the event that I default on the payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorneys' fees. If the debt is assigned to a third-party collection agency, I agree to be responsible for

collection fees and interest due to amount in default.

FMLA Paperwork
Any medical records releases and FMLA paper work requested will In case the balance remains unpaid and any litigation ensues, you will be responsible for our court and attorney fees be subjected to a processing fee. The fee for medical records is $25.00 and the FMLA is $25.00.

Returned Check Fee
Any return check by the bank for "NSF" or "Closed Account" will be charged $25 service fee, in addition to the amount of the returned check. We reserve the right not to accept personal checks from you in the future when your account has a "return check fee" charge.

Surgery Fee
Surgery fee and any balances due will be collected at least 1 week before your surgery. The fee will only include the surgeon's fee. Charges from the hospital and Anesthesia will be filed separately. Also please validate your surgery dates as there is a $150.00 cancellation/rescheduling charge, if cancelled within 7 days prior to surgery.

No Show Policy
There is a $25.00 charge for all no show or appointments cancelled in less than 24 hours of appointment date.

Past due Balance
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.

Self-Pay Policy
Each visit, the patient will be responsible for the payment of services provided, in full.

Out of Network Insurance Policy
Carolina Retina Institute will not file claims to insurance companies we are not contracted with. If you wish to receive medical eye care from our physician, you will be considered a self-pay patient and the self-pay policy will apply to you. If you provide written confirmation to us regarding your out of network benefits, we will provide you with the documentation needed for you to file our claim for personal reimbursement.

Workers Compensation Policy
In order for Carolina Retina Institute to file a claim with your workers comp or other liability carrier, you must provide complete billing information. Without this information, we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. You will be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. Carolina Retina Institute will not bill attorneys for medical expenses.

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

Printed Patients Name _____

Signature of Patient or Responsible Party _____ Date _____