Northern California
Retina Vitreous Associates
Established in 1983

Patient Registration Form

Last Name: ______________________________

First Name: ______________________________

Middle Name: ________________ **Suffix:** ________

Former Last Name: ______________________________

Date of Birth: ____________ **Sex:** ☐ Male ☐ Female

Social Security #: ______________________________

Address: ______________________________

____

City: ______________________________

State: ______________________________

Zip Code: ______________________________

Occupation: ________________________ ☐ N/A

Employer: ________________________ ☐ N/A

Home Phone: (______) _______ - _________ ☐ None

Mobile Phone: (______) _______ - _________ ☐ None

Work Phone: (______) _______ - _________ ☐ None

Email: ______________________________ ☐ None

Contact Preference: ☐ Home ☐ Mobile ☐ Work ☐ Mail

Language: ____________________________ ☐ Decline

Race: ____________________________ ☐ Decline

Ethnicity: ____________________________ ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Emergency Contact: ______________________________

Relationship: ______________________________

Phone: ______________________________

Preferred Pharmacy (Name/Address/City/Zip Code): ______________________________

____

Please enter your medical insurance information below or bring your current insurance cards with you to the appointment. If you are not the plan's subscriber, please enter the name, date of birth, and social security # of the subscriber here.

Primary Insurance: ______________________________

Address: ______________________________

City, State: ______________________________

ID #: ______________________________

Group #: ______________________________

Subscriber Name: ______________________________

Subscriber DOB: ______________________________

Subscriber SSN: ______________________________

Secondary Insurance: ______________________________

Address: ______________________________

City, State: ______________________________

ID #: ______________________________

Group #: ______________________________

Subscriber Name: ______________________________

Subscriber DOB: ______________________________

Subscriber SSN: ______________________________

Please enter the doctor that referred you, your PCP, and any physicians who should receive a copy of your visit summary:

Referring Doctor: ______________________________ ☐ None

Primary Care Doctor or General Physician: ______________________________ ☐ None

Any other physicians: ______________________________

NCRVA Patient Financial Responsibility Policy

Thank you for choosing Northern California Retina Vitreous Associate (NCRVA). We are committed to providing you with the highest quality medical care. Your clear understanding of our Patient Financial Responsibility Policy and payment for services are important parts of our professional relationship. Please let us know if you have any questions about our fees, our policies, or your responsibilities.

Proof of insurance. All patients must complete the patient registration process prior to seeing the doctor. We must obtain a copy of your driver's license or photo ID and current valid insurance card(s) (primary, secondary and tertiary as applicable).

We participate in most insurance plans. If we are contracted with your insurance, we will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including the correct primary and if any, secondary insurance, as well as any change of insurance information, on every visit. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You will be billed after we determine what your insurance assigns to you as coinsurance/deductible or other "patient responsibility". Co-payments are due at the time of service.

If your insurance requires a referral or authorization from your referring physician or primary care physician, we must have that referral/authorization before we can schedule your appointment. You can help ensure a successful new patient visit by asking your referring physician or provider if a referral or authorization has been approved for your visit with NCRVA. Once you are an established patient of NCRVA, certain services or treatments may require prior approval from your insurance. If your insurance denies the approval of the treatment, we may need your help in advocating for a reversal of that denial.

If we are not contracted with your insurance, we will do our best to communicate this to you before your visit. If you fail to provide us with the correct insurance information, your appointment will be cancelled and rescheduled when your insurance information has been entered and verified.

If you have an emergent medical condition, and your insurance coverage cannot be verified prior to your appointment, you will be asked to sign the Patient Responsibility and Insurance Waiver Form to acknowledge that you agree to pay any portion of the charges not covered by your insurance plan.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance continues to deny payment after all attempts have been made to collect, you may be responsible for payment of service and responsible for obtaining, if any, reimbursement from your insurance.

Self-Pay Accounts. If you have no insurance, or do not wish to use your insurance, and you still choose to receive medical care at NCRVA, you will be considered self-pay and will need to sign the Patient Responsibility/Insurance Waiver Form (or Advanced Beneficiary Notice of Non-coverage for Medicare patients) to acknowledge that you are personally responsible for the full payment of the services and treatment provided to you. The full amount will be collected at the end of the appointment, so please bring your preferred form of payment.

If you need surgery, we require payment of our physician's services in full before the surgery date. Our staff will assist with the paperwork, discuss preparations, and tests involved, and surgery scheduling process. However, you will need to contact the hospital and any other physicians who may be a part of your surgery (e.g., anesthesia) directly to get a quote and arrange payment for their services.

If your insurance becomes inactive, or you are covered by insurance plans we are not contracted with, you will be considered self-pay. Please ask to speak with a Billing Specialist to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Co-payments and deductibles. All co-payments must be paid at the time of service. Deductibles are due after the insurance has processed the claim. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. To make payments convenient we accept cash, personal checks, money orders, or credit cards. We also provide you with the option to pay online when you check-in to confirm your appointment, pay online after your visit through email, or by phone by calling the Billing department at 650-268-8075.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly, such as the coordination of your benefits. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance

benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. It is your responsibility to notify our office promptly of any patient information changes (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility. If your insurance company does not pay your claim in 60 days, due to "inactive" coverage, the balance will automatically be billed to you.

Financial Assistance through Manufacturer's or Independent Patient Assistance Programs. Independent nonprofit charitable organizations assist eligible patients with some out-of-pocket costs associated with prescribed medical treatments. Assistance varies and may include help with copayments, deductibles, and/or coinsurance. Eligibility is determined based on a qualifying diagnosis for a specific disease fund and patients may have to meet certain income guidelines criteria. Once we have determined that you will need a treatment, one of our staff or patient financial assistance personnel will explain the program to you and obtain your consent or signature to allow these assistance programs to help us verify your insurance coverage for the treatment, and any remaining out of pocket costs to you. We may ask you to disclose your household size and an estimate of your household income to help the program determine the amount they can help cover for you.

Nonpayment. It is our practice policy that all past due accounts be sent three statements. If payment is not made on the account a single phone call will be made to try to make payment arrangements. Mutually agreeable payment plans may be arranged. If no resolution can be made, the account will be sent to the collection agency and may result in a possible discharge from the practice. If this should occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis].

Patient Refunds:

If you pay for any service that is subsequently paid by a third-party payor and that constitutes a duplicate payment for the said service, the refund shall be made as follows:

1) If the patient requests a refund, within 30 days following the request from the patient for a refund if the duplicate payment has been received, or within 30 days of receipt of the duplicate payment if the duplicate payment has not been received.

2) If the patient does not request a refund, within 90 days of the date NCRVA knows, or should have known, of the receipt of the duplicate payment, NCRVA will notify you of the duplicate payment and a refund of the duplicate payment will be made within 30 days unless you request that a credit balance be retained

Billing Questions: If you have any questions about your medical bill, please contact us at 650-268-8075. We are happy to review your statement and make sure that it is accurate. Please be advised that medical bills are not negotiable.

Our practice is committed to providing the best treatment for our patients. Having a payment policy in place helps us run our practice at peak efficiency while delivering expert care to our patients. Please let us know if you have any questions or concerns.

Patient Acknowledgment:

I have read the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by NCRVA to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate NCRVA to extend credit to me for services provided.

Patient or authorized representative signature: ______________________________ **Date:** ____________

Patient or authorized representative name: ____

Mountain View
2495 Hospital Drive, Ste 545
Mountain View, CA 94040
P: 650-963-3460 | F: 650-963-3480

San Mateo
50 S. San Mateo Dr, Ste 125
San Mateo, CA 94401
P: 650-340-0111 | F: 650-340-9689

Good Samaritan
2512 Samaritan Court, Ste. P
San Jose, CA 95124
P: 408-356-8818 | F: 408-356-8849

East San Jose
200 Jose Figueres Ave, Ste 415
San Jose, CA 95116
P: 408-251-3500 | F: 408-251-3535

Monterey
798 Cass Street, Ste 200
Monterey, CA 93940
P: 831-373-6280 | F: 831-373-0151

Daly City
901 Campus Dr, Ste 215
Daly City, CA 94015
P: 650-994-2100 | F: 650-994-2121

NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____ Date of Birth: _________________________________

I have received a copy of Northern California Retina Vitreous Associates, Inc. Notice of Privacy Practices effective July 2020 and hereby give consent to Northern California Retina Vitreous Associates, Inc. to use and disclose my protected health information as described in the Notice. I also authorize the release/disclosure of my health information on my behalf to the person(s) listed here:

Name: _________________________________ Relationship: ________________________________

Name: _________________________________ Relationship: ________________________________

Patient's Signature: _______________________________________ Date:____________________________________

<u>If the patient is a minor or unable to sign, please complete the following</u>:

☐ Patient is a minor: ________ years of age

☐ Patient is unable to sign because: ____

Signature of Authorized Representative: ____________________________________Date: ______________________

Print Name of Authorized Representative:____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other:____

For Internal Use Only:

If patient or legally authorized representative did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices Jul 2020 given to patient on _____________________________ (date)

☐ In Person ☐ Mail ☐ Email ☐ Other ____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to ☐ Did not respond after more than one attempt ☐ Other ______________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation ____

☐ Telephone contact ____

☐ Mail ____

☐ Email ____

☐ Other ____

Staff Name (please print): _______________________________________ Title: ________________________________

Signature: ____ Date:________________________________

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Medical History & Review of Systems

Patient Name: ______________________ **Date of Birth:** ______________________

Please check all boxes that apply to you.

Endocrine Problems: ☐ None
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other ______________________

Cardiovascular Problems: ☐ None
- ☐ High Blood Pressure
- ☐ Heart Attack or Chest Pain (Angina)
- ☐ Abnormal Heart Beat
- ☐ Heart Failure
- ☐ Angioplasty or Heart Surgery
- ☐ Other ______________________

Respiratory Problems: ☐ None
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- ☐ Other ______________________

Head/Ear/Nose/Throat Problems: ☐ None
- ☐ Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- ☐ Hearing Loss
- ☐ Other ______________________

Digestive Problems: ☐ None
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Other ______________________

Genitourinary Problems: ☐ None
- ☐ Dialysis or Kidney Failure
- ☐ Sexually Transmitted Disease
- ☐ Other ______________________

Musculoskeletal Problems: ☐ None
- ☐ Osteo Arthritis or Rheumatoid Arthritis
- ☐ Migratory or Moving Joint Pains
- ☐ Lower Back Pains
- ☐ Other ______________________

Neurologic/Psychiatric Problems: ☐ None
- ☐ Stroke or Transient Ischemic Attacks
- ☐ Mood Disorder: Depression/Anxiety/etc.
- ☐ Other ______________________

Skin Problems: ☐ None
- ☐ Rashes
- ☐ Sores in Mouth or Genitals
- ☐ Other ______________________

Cancer: ☐ None
- ☐ Type/s: ______________________

____

____

Blood/Immune Problems: ☐ None
- ☐ Bleeding or Clotting Problems
- ☐ Auto-immune Disease ______________________
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Other ______________________

Constitutional Symptoms: ☐ None
- ☐ Fever
- ☐ Fatigue
- ☐ Unexpected Weight Loss or Gain

***"Family"* Eye History (Other than You):** ☐ None
- ☐ Macular Degeneration
- ☐ Retinal Tears or Detachments
- ☐ Glaucoma
- ☐ Other ______________________

Social History: ☐ None
- ☐ Live Alone
- ☐ Live with (relationship) ______________________
- ☐ Retired
- ☐ Occupation ______________________

Habits: ☐ None
- ☐ Tobacco use ______________________
- ☐ Alcohol use ______________________
- ☐ Street Drug use ______________________
- ☐ Herbal/Vitamin Supplements ______________________

____

____

Surgeries: ☐ None

____

____

____

____

Allergies:

____

____

____

____

Please bring all of your medications, supplements and eye drops with you to your appointment or complete the medication list section on the next page.

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Medication List

Patient Name: ______________________________________ **Date of Birth:** ___________________________

Please list all **Eye Drops** that you are using:

Name	**Right, Left or Both Eyes?**	**Number of Drops**	**Frequency** (Once a day, Four times a day, As Needed, etc)

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	**Dose** (mg, mL, etc)	**Frequency** (Twice a day, Four times a day, As needed, etc)

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: ______________________________________ Date of Birth: __________________________

Address: ____________________________________ City / State / Zip: ______________________________

I hereby authorize the disclosure of my health information from:

____
Name of Person / Organization Releasing Information

____
Address City / State / Zip

____
Phone Number Fax Number

To release my information to:

____
Name of Person / Organization Releasing Information

____
Address City / State / Zip

____
Phone Number Fax Number

Information to be released:

☐ Complete Medical Record
☐ Medical Records covering the period with these dates:
from: __________________ to ______________________
☐ Other (please list):_________________________________
____

Purpose of Authorization (check all that apply):

☐ Further Medical Care ☐ Personal Use ☐ School
☐ Attorney ☐ Insurance ☐ Disability ☐ Research
☐ Other:_____________________________________
____

If you would like any of the following information to be released, check the applicable boxes:

☐ Alcohol/Drug Abuse ☐ Physical/Sexual Abuse ☐ Sexually Transmitted Diseases
☐ Abortion ☐ Mental Health Treatment ☐ HIV/AIDS related treatment

This authorization will remain valid until I revoke it or until the expiration date or expiration event specified here:

____

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

______________________________________ ____________________________________ ________________
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority (attach necessary documentation)

For Internal Use Only *– Sent by (name)* ________________________ *on (date)* ____________________ *via (fax or mail)* ___________