FLORIDA RETINA CONSULTANTS

Florida Retina Consultants, P.A.
Phone 863-682-7474

info@frc2020.com

Please be sure to sign pages 2 & 3.

PATIENT INFORMATION

Name: _____

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widow/Widower

Birth Date: _____ Social Security #: _____ Sex: ☐ Male ☐ Female

Address 1: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Alternate Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Alternate Phone: _____

E-mail Address: _____

Race: ☐ Black ☐ White ☐ Native American ☐ Pacific Islander or Alaskan ☐ Asian

Other: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Primary Language: _____

Patient's Employer: _____ Employer Phone: _____

Spouse's Name (or Emergency Contact): _____

Phone: _____ Relationship: _____

Primary Care Physician, if Applicable: _____

General Ophthalmologist/Optometrist: _____

Referring Doctor: _____

INSURANCE INFORMATION

Name of Insured: _____ Social Security #: _____

Primary Insurance: _____ D.O.B: _____

Name of Insured: _____ Social Security #: _____

Secondary Insurance: _____ D.O.B: _____

COMPLETE IF PATIENT IS LESS THAN 18 YEARS OF AGE OR A STUDENT

Name of Insured Parent: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____

Social Security #: _____ Date of Birth: _____

Employer: _____

Insured Signature: _____

FINANCIAL ASSIGNMENT AND AGREEMENT

1. I realize that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I also realize it is my responsibilty to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.**

Signed: (Patient or parent/guardian if minor)

_____ Date: _____

MR#: _____

Florida Retina Consultants

Scott M. Friedman, M.D. Nader Moinfar, M.D.

Patient Consent for Use and Disclosure of Protected Health Information and Consent for Treatment

I hereby give my consent for the Physicians and Staff of Florida Retina Consultants (FRC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I also acknowledge that The Notice of Privacy, which describes such uses and disclosures more completely, has been offered to me by FRC for my review.

I have the right to review the Notice of Privacy Practices prior to signing this consent. FRC reserves the right to revise The Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FRC, 2202 Lakeland Hills Blvd., Lakeland, FL 33805.

With this consent, FRC 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.

With this consent, FRC may e-mail to my home or other alternative location anytime to assist the Practice in carrying out TPO, such as appointment reminders, normal laboratory results, and patient statements. I have the right to request that FRC restrict how my PHI is used or disclosed to carry out TPO. The Practice is not required to agree to my requests restrictions, but if it does, it is bound by this agreement. I must submit these restrictions to the Practice in writing, By signing this form, I am consenting to allow FRC to use and disclose my PHI to carry out TPO. I am also acknowledging that The Notice of Privacy Practices has been offered to me for my review.

I may revoke the above 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, FRC may decline to provide treatment to me.

I give my permission to FRC to speak or correspond with the following people in person, mail, telephone, or electronic communication, regarding my personal health information and financial information:

Please check all that are appropriate:

☐ **Anyone** _____ ☐ **Children** _____

☐ **Spouse**_____ ☐ **Caregiver/Other** _____

Patient Name: _____

_____ _____

Patient/Parent/Legal Guardian Signature ***Date***

_____

Witness