AUSTIN RETINA ASSOCIATES PATIENT INFORMATION

NAME: Last First Middle Initial

MAILING ADDRESS or NURSING HOME NAME & ADDRESS:

CITY: STATE: ZIP CODE:

TELEPHONE: HOME: CELL: WORK:

DATE OF BIRTH: / / AGE: RACE:

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED GENDER: MALE FEMALE

DRIVERS LICENSE # STATE: SS#:

EMAIL:

SPOUSE / PARENT / GUARDIAN NAME: CELL: ( )

Circle One

EMERGENCY CONTACT: PHONE: ( ) CELL: ( )

MEDICARE #: MEDICAID #:

HEALTH INSURANCE NAME:

INSURED NAME: INSURED DATE OF BIRTH: / /

INSURED ID#: GROUP #: RELATIONSHIP TO PATIENT:

OTHER HEALTH INSURANCE NAME:

INSURED NAME: INSURED DATE OF / /

INSURED ID#: GROUP #: RELATIONSHIP TO

REFERRING PHYSICIAN NAME: (first) (last)

ADDRESS: CITY: STATE ZIP:

PRIMARY CARE PHYSICIAN NAME: (first) (last)

ADDRESS: CITY: STATE ZIP:

I authorize any and all insurance benefits, to which I am entitled for services rendered by Austin Retina Associates, to be paid directly to Austin Retina Associates. I agree it is my responsibility to pay charges not covered by my insurance. I authorize any holder of medical or other information about me to release to the Social Security Administration, HCFA, and its subsidiaries, and other insurance carriers or health care providers, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original. This authorization is in effect until I choose to revoke it.

SIGNATURE:_____DATE:___/_____/_____

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ASSOCIATES

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Jose Agustin Martinez, M.D.
James W. Dooner, M.D.
Mark Levitan, M.D.
Peter A. Nixon, M.D.
Robert W. Wong, M.D.
Shelley Day Ghafoori, M.D.
Ryan C. Young, M.D.

Please indicate if you have given someone other than yourself medical Power Of Attorney or if someone is your legal guardian.

❑ I am my own Power of Attorney

❑ I have assigned another individual as my Power of Attorney

If applicable, please fill out the following:

Name of Power of Attorney: _____

Relationship to Patient: _____

Phone number to contact POA: _____

In addition, please provide Austin Retina with a copy of the signed POA document stating who can exercise your rights and make choices about your health information.

_____

Patient Name

_____ _____

Patient Signature Date

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AUSTIN RETINA ASSOCIATES FINANCIAL POLICY AGREEMENT

We are dedicated to providing the best possible care and medical service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is our financial policy, and by accepting care from Austin Retina Associates, PA ("ARA"), you agree to be bound by this policy. This form cannot be modified by the patient/guardian without our written consent. Your signature acknowledges agreement to this policy, which is required prior to services being provided.

PROOF OF INSURANCE AND IDENTITY

- For each appointment, you are required to present your current insurance card(s) and a valid photo ID. It is your responsibility to notify our practice regarding any insurance or address changes.

PAYMENT IS DUE AT THE TIME OF SERVICE

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

PATIENTS WITH OUT-OF-NETWORK INSURANCE PLAN

- If you have insurance coverage with a plan for which we do NOT have a contract or prior agreement, payment for your care and treatment is due at the time of service.

PATIENTS WITH IN-NETWORK INSURANCE PLAN

- ARA is contracted with many insurers and health plans to accept assignment of benefits. As contracted Providers, we will send a claim to your insurance or health plan, and at the time of service will only require you to pay the authorized co-payment, deductibles and/or coinsurance. However, if after your insurance or health plan adjudicates the claim and a balance remains owe on your account for the service, you agree to pay the remaining amount owed upon receipt of a statement from ARA for the balance.
- In the event your insurance or health plan determines a service is "not covered," you will be responsible for the complete charge for ARA's service. Payment is due upon receipt of a statement from our office for the amount owed.
- If your insurance or health plan is one that we have an agreement with, but you do not present your insurance card at the time of service, you will be required to sign a waiver, your record will

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be recorded as "self-pay", and payment in full by you will be required at the time of service.

- If it is discovered that you did not present the correct insurance or health plan ID card at the time of service, you will be responsible for the charges if they are denied by your correct insurance or health plan.
- Some insurance or health plans require an official referral/authorization number or form to be presented to ARA prior to your service. If the patient seeks medical services without this authorization in place prior to services being provided, you will be required to sign a waiver, and full payment by you will be collected at the time of service. It will be your responsibility to seek reimbursement, if any, from your insurance or health plan.

PROMPT PAY DISCOUNTS

- Austin Retina benefits from administrative cost savings from payment by patients at the time of services. As a result, patients will be eligible for the then applicable discount being provided by ARA. Patients are not eligible for discounts if they have outstanding balances from prior services that are still owed to ARA.

MINOR PATIENTS/ WARDS

- Parent/ guardians of the minor/ wards are responsible for payment of the bill for services.
- Payment arrangements must be made in advance for unaccompanied minors.

COLLECTION OF UNPAID BALANCES

After reasonable efforts to collect unpaid balances owed to ARA are completed, which shall be determined in ARA's sole discretion, ARA may seek the assistance of a collection agency or lawyer to obtain payment of all amounts owed ARA. If such is required, the patient shall be responsible for all reasonable collection expenses to include, but not limited to, collection agency expenses, attorney's fees and expenses, expert fees, and costs of court. Sole and exclusive venue for any dispute regarding amounts owed by you for yourself or a minor/ ward (as parent or guardian) shall be solely and exclusively in the federal, state and county courts of Travis County, Texas. If you have any questions regarding your balance, please call our billing office at (512) 451-0103.

GENERAL NOTES REGARDING ARA'S FINANCIAL POLICY

- If, after the patient's insurance or health plan makes a payment and a credit balance results on the patient's account, the credit balance will first be applied to any other balances due by the patient to ARA. After all amounts owed to ARA are paid, a refund will be issued within 30 days from the date the credit balance is identified.

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- Requests for copies of medical records, and completion of FMLA or other forms, are billable to the patient as patient-responsible fees. Please request our separate form regarding fees for copies of records/forms.

PATIENT ACKNOWLEDGEMENT

I have read and understand the financial policy of ARA and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by ARA.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party **Date**

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WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I _____, have been provided a
(Please print patient name)
copy of Austin Retina's Notice of Health Information Practices.

I have had an opportunity to read the Notice of Health Information Practices. I understand that I may ask questions of the Privacy Officer if I do not understand any information contained in the Notice of Health Information Practices.

_____
Patient Signature

_____
Date

_____
Authorized Representative of Patient

_____
Relationship to Patient

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I _____, authorize Austin Retina
(Please print patient name)
Associates to release all medical information including test results and future appointment dates and/or times to the following friends or relatives:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Please check all that apply where we may leave a message for you.

_____Your answering machine

_____At your place of employment

Other: _____

May we send you a postcard regarding appointments?

_____Yes _____No

_____ _____
Patient / Guardian Signature Date