MARYLAND RETINA

Patient Registration Form

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Email: _____ SSN: _____

Birth Date: _____ Marital Status: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

Doctor who referred you here _____ Phone _____

Primary care doctor _____ Phone _____

Pharmacy _____ Phone _____

Pharmacy Location _____

Insurance Information

Please note that you are responsible to provide accurate insurance information.
Any claim denial caused by inaccurate insurance information provided on this form may cause you to be responsible for the full balance of your medical services.

Primary Insurance		**Secondary Insurance**	
Insurance ID:		Insurance ID:	
Group No.:		Group No.:	
Policy Holder Name and relation:		Policy Holder Name:	
Policy Holder DOB:		Policy Holder DOB:	

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *City/State/Zip*

Primary Phone: _____ Relationship: _____

Financial Policies

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the physician. We must obtain a copy of your driver's license (or other photo ID) and current valid insurance cards to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

PATIENTS WITH INSURANCE: Although we bill your medical insurance company for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your medical insurance, we may contact you for assistance. If your medical insurance denies coverage for any reason, you will be responsible for payment in full within thirty (30) days of receipt of your billing statement.

CLAIM FILING: For any medical services, our staff will file a medical claim on your behalf, provided we have your current medical insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package.

Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. While we attempt to assist our patients with any unpaid claims, any disputes with your insurance carrier are not the responsibility of our practice.

Ultimately, the patient is responsible for their charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know and understand the details of their insurance contract.

BALANCES: When your medical insurance company processes your claim, they will provide you with an Explanation of Benefits (EOB). The EOB will explain what the insurance company has agreed to pay, and what they expect you to pay. Many insurance companies agree to pay only a percentage of the charges, with the remaining balance being the patient responsibility. If you are not receiving EOBs from your insurance company, contact them with questions about how they processed a claim.

UPDATES TO INSURANCE: It is your responsibility to provide Maryland Retina with correct, up-to-date insurance information. If there are changes to the insurance, you must advise Maryland Retina prior to your appointment, otherwise you may be responsible for full payment of services.

CO-PAYS, CO-INSURANCE, and DEDUCTIBLES: It is your responsibility to know your medical insurance co-pay, co-insurance, and deductible responsibilities. Co-pays are routinely collected at the time of service. Maryland Retina reserves the right to collect co-insurance and deductibles at the time of service as well.

AUTHORIZATION FOR TREATMENT: Some insurance plans require you to obtain a prior authorization for specialist services. While we request authorization on your behalf, some insurance companies do not have rapid response times. This may result in a delay in treatment. If you choose to pursue treatment without authorization, you are responsible for all unauthorized billed services.

REFERRALS: Because we are a specialty practice, certain insurance plans require a referral from your primary care physician to be seen at our office. It is your responsibility as the policy holder to be aware of referral requirements of your health plan. If a referral is required and you do not obtain a valid referral in time for your appointment, Maryland Retina will reschedule your appointment. If you are seen without referral and your insurance denies the claim, you will be charged for services at our self-pay rates for any services provided.

NON-COVERED SERVICES: Please be aware that some services may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be informed of any non-covered services in advance of treatment and payment for those services will be required prior to treatment. You will be required to sign an advanced beneficiary notice to receive non-covered services.

OUT OF NETWORK: If your medical insurance company considers our office or our provider to be Out of Network, your insurance may provide less coverage for your services, and hold you responsible for higher co-pays, co-insurance, or deductibles. If you want to know if Maryland Retina or Dr. Sadiq Syed is within Network with your medical insurance plan, you will need to call them and ask.

DUAL COVERAGE: You are responsible for providing us with all billing information for primary, secondary, and tertiary medical insurance plans. If you have Medicare as Primary Insurance, you are responsible for

Coordinating your secondary benefits with Medicare. We will not mail secondary claims when you have not coordinated your Medicare and secondary benefits. To do this, you can contact Medicare's Benefit Coordination Center at 855-798-2627.

DELINQUENT ACCOUNTS: We request that all patient balances be paid within 2 weeks of receiving a patient billing statement. Late fees will be assessed on accounts not paid within thirty (30) days of receiving the billing statement. If the patient balance on your account is over ninety (90) days past due from receiving a billing statement, your account will be referred to a collection agency. You will be responsible for a collection fee of 35% to 50% of the balance, in addition to any necessary attorney and / or court fees in addition to the original balance. Upon referral to a collection agency, you will receive notification of discharge from Maryland Retina.

Any returned check will be subject to a returned check fee of $35.

PATIENTS WITHOUT INSURANCE: Maryland Retina has a self-pay fee schedule for patients who are not insured. Our fees cannot always be determined in advance, since they depend on the actual service(s) provided. Payment for all services is due at the time of service.

For Self-Pay patients scheduled for surgery, payment for Dr. Syed's surgical fee is due one (1) week prior to surgery. If payment is not received one week prior, surgery will be cancelled.

Office Policies

NO-SHOW POLICY: Our office requires twenty-four (24) hour notice of cancellation for scheduled appointments. If we are not notified twenty-four (24) hours prior to your appointment, you will be charged a $25.00 "No-Show" fee, due prior to your next appointment.

FEES FOR COPYING MEDICAL RECORDS: For records to be sent to another medical provider, a preparation fee of $22.88, plus $0.50 per page of your medical record, plus any necessary postage will apply. If you wish to receive a copy of your medical record, a fee of $0.50 per page of your medical record and any necessary postage fees will apply.

FEES FOR FILLING OUT FORMS: A charge of $25 will apply to standard FMLA forms. Any other forms filled out regarding your medical condition will have a charge ranging from $25 to $75 depending on the length and complexity of the form.

We do NOT provide Drivers License form services as we do not provide eyeglass prescription services (refraction). Please contact your optometrist or general ophthalmologist for Drivers License forms.

Consent to Treat

I hereby authorize Maryland Retina and all its physicians and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Authorization and Assignment of Benefits

For all insurance types, I authorize Dr. Sadiq N. Syed and Maryland Retina to release any medical information that may have a bearing on the determination and / or payment of my claim.

I request payment is made directly to Sadiq N. Syed, M.D., or Maryland Retina.

I acknowledge that I am responsible for payment if this assignment is not honored.

I understand that I am responsible for all co-payments, coinsurances, and deductibles that I may have with my insurance.

I further understand that I have been provided with service and it is my responsibility to know my own insurance coverage and to be aware of services that may or may not be covered.

I have read and understand all the above policies, and I agree to comply with them.

I attest that all information is true and accurate to the best of my knowledge.

Printed Name: _____

Signature: _____ Date: _____

Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient can review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

I authorize Maryland Retina to disclose medical or financial information to the following individuals:

_____ _____

_____ _____

_____ _____

Signature of Patient: _____ **Date:** _____