George J. Ko, MD, FACS
Kenneth Fung, MD
Syed Mahmood Ali Shah, MD
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Patient Information Form

Patient Demographics				
Name (last, first middle)	**Descriptors**		**Marital Status**	**Date of Birth**
	☐ He ☐ Other ☐ She ☐ They	☐ M ☐ F ☐ decline		
Social Security #	**Mobile #**		**Home #**	
Address	**City**	**St**	**Zip**	**Email**
Preferred Pharmacy & Location				

Emergency Contact				
Contact Last Name	**First**	**Mdl**	**Relationship**	**Phone #**

Work Contact		
Employer	**Contact or address**	**Phone #**

Insurance Details

This is **required after a copy of card** is received, as you are signing authorization to bill this insurance, telling us which is primary, and allowing us to assume funds/payment from them.

Primary Insurance	Member ID #	**Secondary Insurance**	Member ID #

Physician information				
Patient's Physician(s) / Group	**City**	**State**	**Telephone/contact**	**Information**
PCP:				
Other:				

Other Patient Information: Interpretation, transportation, caretakers, or key details to assist us to meet your needs.

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I authorize treatments to the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information required. I have read and understood the Financial and Privacy Practices Policies provided by Retina Institute of Washington.

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

Notice of Privacy Practices

YOUR INFORMATION · YOUR RIGHTS · OUR RESPONSIBILITIES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

This page is intended as a summary of the Notice. Please review the remainder of the Notice for more details.

Your Rights

You have the right to:

- Request a copy of your paper or electronic medical record
- Request a correction to your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information we share
- Get a list of certain disclosures we have made of your information
- Get a copy of this privacy notice
- Choose someone to act for you, in accordance with certain legal requirements
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Include you in a hospital directory
- Raise funds & Marketing Purposes

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist in a disaster relief effort

Patient Acknowledgment of Receipt of Privacy Practices

I,_____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights in regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact Retina Institute of Washington's parent corporation and/or their compliance team:

Comprehensive EyeCare Partners

Compliance Hotline
702-463-7653

50 S. Stephanie Street, Suite 101
Henderson, NV 89012

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature_____ Date___/___/___

For Office Use Only:

For Office Use Only:

We made a good faith effort to obtain an acknowledgment of_____receipt of our Notice of Privacy Practices. Despite these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons:

- ☐ Patient refused to sign (date of refusal) _____/_____/_____
- ☐ Communication barriers prevented obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other_____.

Attempt was made by: _____ Date____/____/_____

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Benjamin Reiss, MD
Minhee Cho, MD

Our Financial Process

Thank you for choosing us for your retina care needs. We are committed to providing you with the best quality and affordable care. As your care provider, we believe it is important to directly communicate with you relating to your financial responsibilities. The following common items, and how they will be handled, are noted here for your acceptance of terms prior to service.

Insurance:

We participate in most insurance plans, including Medicare and Medicaid. While the Retina Institute of Washington will bill insurances on your behalf, knowing your insurance benefits is your responsibility and you are ultimately responsible for your service and its bill. By signing this form, you are Assigning Your Benefits as they are paid from insurance to Retina Institute of Washington. Please contact your insurance company with any questions you may have regarding your coverage. If you are not insured, payment in full is expected at each visit. If you cannot pay your balance in full before the statement due date, you be expected to contact us to set up a payment arrangement.

Co-payments:

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Please Sign Here _____ Patient or Guarantor Signature ___/___/___ Date

Accepting our financial Policy _____ Printed Name of Patient

(Notations continue on back)

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Proof of insurance & valid identification:
We must obtain a copy of your current insurance card to provide proof of insurance, as well as a copy of your ID/License. For your protection you will not be able to be seen at our office without a valid ID. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

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. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Small balance both directions: In order to save help save the planet and use resources wisely, it is not appropriate to mail bills or send refund checks for patient accounts with total balances of less than $5.00 (debit or credit). These balances will be written off after a reasonable period.

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.

Nonpayment: Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Please contact us to set up a payment plan if needed.

Non-Sufficient Funds: There will be a $35.00 NSF fee on returned checks.

Thank you for reading our payment policy.
Please let us know if you have any questions or concerns.