901 N. Main St.
McPherson, KS 67460
P: 620-245-0556
F: 620-245-0503

ESTHER V RETTIG M D P A
Ophthalmologist (Eye MD)

2525 S. Ohio St.
Salina, KS 67401
P: 785-371-2425
F: 785-371-2427

PATIENT REGISTRATION FORM

Patient Information as of
(Please Print Legibly & Fill In or Correct All)

DEMOGRAPHICS

Patient's Name: **Nickname:**

Date of Birth: **Age:** **Sex:** ☑ Female ☐ Male ☐ Other

SSN: **Marital Status:** ☑ Single ☐ Married ☐ Widowed ☐ Other

Address: **City:** **State:** **Zip Code:**

CONTACT INFORMATION

Home Phone: **Cell Phone:**

Are there any restrictions to contacting you? ☑ No ☐ Yes

Email Address: Restrictions:

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone (☐ Text) ☐ Work Phone ☐ Email

IF PATIENT IS A MINOR (UNDER AGE 18)

Parent Name: **Parent DOB:**

Sex: ☐ Female ☐ Male ☑ Other

Parent SSN:

Address: **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:**

Are there any restrictions to contacing you? ☑ No ☐ Yes

Email Address: Restrictions:

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone (☐ Text) ☐ Work Phone ☐ Email

EMPLOYER

Employer: **Occupation:**

Address: **City:** **State:**

Are there any restrictions to contacing you? ☑ No ☐ Yes

Work Phone: **Ext.:** **Zip Code:** Restrictions:

SPOUSE/SIGNIFICANT OTHER ☐ Emergency Contact

Name: **Date of Birth:** **Phone Number:**

INSURANCE INFORMATION ☐ Vision Plan

Primary Insurance: **ID#:**

Subscriber DOB:

Subscriber Name:

Patient relationship to subscriber: <<Select>>

Do you require a referral? ☑ No ☐ Yes

SECONDARY INSURANCE ☐ Vision Plan

Secondary Insurance: **ID#:**

Subscriber Name: **Subscriber DOB:**

Patient relationship to subscriber: <<Select>>

Do you require a referral? ☑ No ☐ Yes

MEDICAL INFORMATION

Who is your primary care doctor? City/State:

Preferred Pharmacy: City/State:

Have you seen an Ophthalmologist/Optometrist in the last 12 months? (If yes, name of the Doctor)

Were you referred by an Ophthalmologist/Optometrist? (If yes, name of the Doctor)

Do you have a **medication list** with you today? If yes, please notify a patient services representative or technician so we can make a copy.

Name Date

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LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (FORM 7.31)

Please print all information. Form must be **signed** and **dated**.

Patient Name:

SSN: **Date of birth:**

Description of information to be disclosed – I authorize **Esther V. Rettig, MD PA and her staff** to disclose the following protected health information about me to the person(s)/entity listed below:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ office notes
☐ lab results, pathology reports
☐ x-rays
☐ financial history report (previous 3 years only)
☐ nursing home, home health, hospice, and other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ only disclose the following:

Who will be authorized to receive information? Would you like this person listed as your emergency contact? ☐ **No** ☑ **Yes**

Individual/Entity Name:

Address:

Phone/Fax:

Email*:

***Secure Communication** – Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate fax or email as your preferred method of disclosure if this is of concern to you.

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient request
☐ Other (please specify):

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

Patient or authorized representative signature

Date

You have the right to receive a copy of signed authorizations upon request.

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HIPAA STATEMENT

Name:

Date of Birth:

- We are required by applicable federal and state law to maintain the privacy of your health information.
- We are also required to give you the Notice regarding our privacy practices, our legal duties, and your rights concerning your health information.
- We must follow the privacy practices that are described in the Notice while it is in effect.
- This Notice takes effect 09/23/2013, and will remain in effect until we replace it.
- You may request a copy of our Notice at any time.
- For more information about our privacy practices, please contact us.

I acknowledge that I have been given the Notice of Privacy Practices for Esther V. Rettig MD PA.

Patient/Guardian Signature

Date

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FINANCIAL POLICY

Name:
Date of Birth:

Welcome! Thank you for choosing Esther V. Rettig, MD PA. We understand you have a choice in choosing an eye care provider. We are happy you entrusted us to serve your eye care needs.
In an effort to provide you with timely and cost-effective care, we ask that you take a moment to read our updated financial policy.

INSURANCE:

- It is the responsibility of the patient/guardian to provide **accurate** and **timely** insurance information. Inaccurate or untimely information that results in denial or non-coverage by your insurance company will result in the responsibility falling on the patient/guardian for payment.
- An insurance policy is a contract between the patient, the patient's employer, and the insurance carrier. It is your responsibility to resolve any questions or disputes with your insurance carrier regarding benefits: for example, what treatment is covered and any out of pocket expenses.
- Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered.
- It is your responsibility to make sure we are listed on your insurance plan. If your insurance requires a referral: for example, HMO and VA plans, it is your responsibility to make sure the referral is in place prior to your appointment. We will be happy to help you if needed. Failure to have a referral in place will result in cancellation of your appointment until the referral is received.
- I authorize payment directly to **Esther V. Rettig MD PA** for all benefits payable to me under terms of insurance policy for treatment of services provided to me or my dependents.
- I authorize the release of any medical information necessary to process such insurance claims.

NO INSURANCE/OUT-OF-NETWORK or WE DO NOT PARTICIPATE IN YOUR PLAN:

- If you have no insurance, payment in full will be due prior to seeing the doctor unless other arrangements have been made with our billing department.
- If we are considered Out-of-Network, your out of pocket expenses will be greater than if In-Network. Please check to see if our office is considered In- or Out-of-Network with your insurance plan.
- If we do not participate in your plan, we are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized statement so that you may submit the charges to your insurance company for possible reimbursement.

BALANCES/PAYMENT:

- Copayments and refraction fees are due on the day of your appointment. Any balance due after insurance payments will be billed to you.
- If balances due are not paid within 30 days from the statement date:
  - A $15.00 late fee will be added to the second statement.
  - A $15.00 late fee will be added to the third statement
  - If no payment is made within 10 days of receiving the third statement, your account will be placed for collections.
- For your convenience, we accept the following methods of payment: Cash, Check, Money Order, Visa, Mastes rCard, Discover, American Express and Care Credit. You can also pay your bill online at: www.esthervrettig.com.
- Payment plans are available with a debit/credit card on file.
- A $35.00 fee will be charged for all returned checks and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.

COLLECTIONS:

- In the event that we have to turn your account over to a collection agency:
  - There will be a 15% collection fee added to your delinquent account.
  - Any attorney's fees will be your responsibility.
  - Your account balance will need to be paid in full before scheduling/keeping any future appointments.
- Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency-only basis for the next 30 days, giving you time to find a new source of medical care.

MISSED APPOINTMENTS:

- A 24-hour notice is required for cancellation of appointments.
- Missed appointments will be considered a "no show".
  - The first "no show" within a 1-year period may be assessed a $25.00 fee.
  - A second "no show" within a 1-year period may be assessed a $50.00 fee.
  - A third "no show" within a 1-year period will result in dismissal from our practice.

I have read and fully understand the financial policy set forth by Esther V. Rettig, MD PA.

Parent/Guardian Signature:_____ **Date:**_____