Vitreoretinal Associates, PLLC

Patient Information

Name(Last)	(First)	(M.I.)
Previous Last Name	Nickname	

SSN	Birth Date	Age	Sex

Address (Street)		(Apt/Unit)
(City)	(State)	(Zip)

Race	Primary Language	Ethnicity
Marital Status	Do you need an interpreter? Yes / No	

Primary Care Doctor	Fax #
Referring Provider	Fax #
Eye Doctor (or Optometrist)	Fax #

Contact Information

Home Phone	Ok to leave a message? ☐ Yes ☐ No	
Day Phone	Ok to leave a message? ☐ Yes ☐ No	
Cell Phone	Ok to leave a message? ☐ Yes ☐ No	
E-Mail	Ok to send a message? ☐ Yes ☐ No	
Emergency Contact	Relationship	
Emergency Phone	Ok to leave a message? ☐ Yes ☐ No	

Pharmacy Name	Location
Pharmacy Fax #	Phone #

Billing Information

Are you uninsured or self pay? ☐ No ☐ Yes, I understand that by selecting this option I am responsible for the full balance of my visit.	
Primary Insurance	
Does your insurance require a referral to see a specialist?	☐ Yes ☐ No
Secondary Insurance	
Patients 18 or Over: If your insurance plan(s) will not cover all or part of the fees, or if you are Self Pay, you will be responsible for the balance.	
Minor Patients: If your insurance plan(s) will not cover all or part of the fees, or if you are Self Pay, who is responsible for the balance?	
Guarantor Name	DOB
Relationship to Patient	Phone #

Signature of Patient, Patient's Guardian or Patient Representative Date

PROLIANCE SURGEONS®

Release of Information:

I give permission to the following person(s) to speak with anyone from Vitreoretinal Associates, PLLC about my eye condition, billing information, and any other relevant information.

1. Name & Relationship: _____

2. Name & Relationship: _____

3. Name & Relationship: _____

Patient Initials:_____

Patient Financial Responsibilities:

I acknowledge that I have received and reviewed the Financial Policy.
I accept full financial responsibility for all items or services, which are determined by my insurance(s) not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with an insurance plan or in the benefit summary the insurance plan furnished to the patient; and treatment or tests not authorized by the insurance plan.

Patient Initials:_____

Referral Policy:

I, the undersigned, acknowledge that my insurance may require a referral or authorization before it will pay for my visit(s). If a referral or authorization is required and not received for my visit(s), I understand that I am responsible for the total amount of the exam, test and/or procedure.

Patient Initials:_____

Acknowledgment of Notice of Privacy Practices:

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.

By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

Print Patient's Name: **Date of Birth:**

Signature of patient or guardian: **Date:**