RETINA CONSULTANTS OF MINNESOTA

The following information is provided to help you prepare for your upcoming visit. In this packet, you will find:

1. Patient Demographic Information page
2. Medical History Questionnaire
3. Financial Policy
4. If you have been scheduled for an urgent evaluation that may require surgery, please see the enclosed Patient Instructions for Pre-Surgical Evaluation.

Some insurance plans require a referral in order to pay for services.
If a referral is required, it is the patient's responsibility to secure the necessary referral prior to the visit.

Your Appointment Day:

1. Bring your completed medical history questionnaire & list of medications
2. Bring your Photo ID
3. Bring your current Insurance Card
4. Bring your co-pay, if required by your Insurance Payer
5. Your eyes **will be dilated** so bring a driver. The effects of the dilation can last up to several hours or even into the next day.
6. Your appointment may last **1 1/2 to 2 1/2 hours.**

If you have any questions, please call the Site where your visit will take place.
For locations and contact information, please visit our website at **www.RetinaMN.com**.

Thank you for choosing Retina Consultants of MN as your retina care specialist. The physicians and staff of are all committed to providing you with high-quality care in an efficient and compassionate environment.

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Patient Demographic Information

Patient Name:_____ **Birthdate**:_____

Address:_____ **Social Security Number**:_____

City:_____ **State**:_____ **Zip Code**:_____

Cell Phone:_____ **Home Phone**:_____ **Work Phone**:_____

May we leave a detailed message at/with person answering: (Circle) Cell Home Work

Gender: (Circle) Male Female **Email Address**:_____

Sexual Orientation: (Circle) Heterosexual Homosexual Bisexual Something Else Don't Know Decline

Gender Identity: (Circle) Male Female Transgender Other Decline

Race: (Circle) American Indian Asian Black/African American Native Hawaiian/Pacific Islander White Other Decline

Preferred Language:_____ **Ethnicity**: (Circle) Hispanic/Latino Not Hispanic/Latino Unknown Decline

Marital Status: (Circle) Single Married Widowed Divorced Decline

Employment Status: (Circle) Student Full Time Part Time Retired Self

Occupation:_____ Employer_____

Employer Address_____ Phone:_____

Responsible Party: (Circle) Self Other If Other, please provide name & birthdate:_____

Emergency Contacts: **Ok to discuss care?**

Name/Relationship:_____ Phone_____ Yes No

Name/Relationship:_____ Phone_____ Yes No

Referring Eye Doctor/Clinic

Physician:_____ Clinic:_____

Address:_____

Phone:_____ Fax:_____

Primary Care Physician/Clinic

Physician:_____ Clinic:_____

Address:_____

Phone:_____ Fax:_____

Signature:_____ Date:_____

Relationship:_____ Chart#:_____

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MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

MEDICATIONS: _____

PAST EYE SURGERIES: _____

Do you currently have any problems in the following areas?	Yes	No	DESCRIBE
RECENT ILLNESS			
EAR NOSE THROAT (hearing, sinus)			
HEART (chest pain, heart rhythm)			
RESPIRATORY (asthma, emphysema)			
KIDNEY/URINARY (infections, stones)			
BONES (arthritis, fractures)			
SKIN (rashes, lesions, cancer)			
NEUROLOGICAL (strokes, seizures, dizziness)			
EMOTIONAL (anxiety, depression)			
ENDOCRINE (thyroid, weight changes)			
BLOOD (anemia, bleeding, bruising)			
ALLERGIES (medication, tape, environmental, dye, fluorescein, latex)			

HAVE YOU BEEN IN THE HOSPITAL RECENTLY? IF SO, WHAT FOR? _____

ARE YOU DIABETIC? Y N HOW LONG? _____ UNDER CONTROL? Y N

DO YOU HAVE HIGH BLOOD PRESSURE? Y N CANCER? Y N TYPE? _____

OTHER MEDICAL PROBLEMS: _____

HAVE YOU HAD ANY MAJOR SURGERIES IN YOUR LIFE? Y N WHAT TYPE?

FAMILY HISTORY: GLAUCOMA DIABETES RETINAL DETACHMENT MACULAR DEGENERATION

WHO HAS IT: _____

WHAT IS YOUR OCCUPATION? _____

DO YOU DRIVE? Y N DO YOU SMOKE? Y N DO YOU DRINK ALCOHOL? Y N

SIGNATURE: _____ DATE: _____

Retina Consultants of Minnesota
Financial Policy

Thank you for choosing Retina Consultants of Minnesota as your healthcare provider. We are committed to your treatment being a successful experience. Our goal at Retina Consultants of Minnesota is to serve your medical needs as well as we possibly can. We also want to make the billing a non-issue right from the start. To achieve this, our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

YOUR RESPONSIBILITY: Please bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you.

If you do not have insurance, we require payment of initial estimated charges (minimum $350) at the time of service for each appointment.

IDENTIFICATION: Due to widespread insurance fraud and identity theft, picture identification is required when you register in our office. We require that you update your address and telephone number with us whenever there is a change. We will be verifying this information, along with other demographic information (name, date of birth, emergency contact and primary care provider) at every visit.

INSURANCE:

Plans in which we are participating providers: As a participating provider, we will bill your insurance carrier. We accept the charge determination of the contracted carrier as the full charge, and bill the deductible, coinsurance and noncovered services to the patient.

You are to pay insurance required copays at the time of service. If you are unable to make this payment, we will reschedule your appointment to a time when you are able to pay your copay. You may also contact our business office to make financial arrangements.

If a referral is necessary, you are responsible for getting proper referral information and authorization in advance of your appointment. You will be responsible for payment of services denied for lack of referral and/or pre-authorization.

We will bill your secondary carrier, but you are responsible for any balances after your insurance has cleared.

Plans in which we are non-participating providers: We will bill your insurance company as a courtesy and absorb the costs incurred for this billing. We require you pay in full at the time of service. Your insurance company will send payment directly to you.

Workers Compensation: You must provide us with the name of work comp carrier, the name and phone number of the claim adjuster, the work comp claim number and/or human resources director or benefits manager.

Self-Pay: All cash patients and patients without valid insurance information are considered Self-Pay Patients and must pay for services at the time the service is provided. **A minimum deposit of $350 is required prior to being seen by our technical staff and physicians at every visit.** If you and your physician determine that you need additional appointments, treatments or testing you should contact the Business Office at (952) 897-1175 to make payment arrangements prior to scheduling. If you suffer from financial hardship and desire consideration of alternate payment options, you will be asked to complete a Hardship Application.

BALANCES:

Credit Balance**:** If an encounter has a credit balance, the patient grants permission to transfer that credit to another open encounter with Retina Consultants of MN.

Payment Processing: We accept Amex, Mastercard, Visa, Discover, debit cards, checks and cash. When you provide a check as payment, you authorize us either to use information from you check to make a one-time electron funds transfer from you account or to process the payment as a check transaction.

Outstanding Balances: We urge you to keep your account current to avoid any misunderstanding with our office. Accounts balances past due over 30 days may be sent to an outside agency for collections. If you need to make special payment arrangements, it is your responsibility to contact our Business Office before your account is turned over to an outside agency. Once your account is sent to collections, you will need to contact the collection agency to make payment arrangements.

Retina Consultants of Minnesota
Financial Policy

OUR RESPONSIBILITY: You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the No Surprises Act, providers of patients who don't have insurance or who are not using insurance are required to provide an estimate of the bill for any non-emergency medical items and/or services.

Additionally, when you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

ASSIGNMENT OF BENEFITS

You authorize the release of any information relating to all claims without obtaining my signature on each claim benefits submitted on behalf of myself and/or dependents. You authorize payment directly to Retina Consultants of Minnesota for all medical and major medical benefits present and future for myself and/or dependents. I understand that I am financially responsible for all copayments, deductibles or amount not covered by my insurance carrier.

Signature Date

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Patient Instructions for Pre-Surgical Evaluation and Potential Surgery

1. **You are being scheduled for a "Pre-Surgical Evaluation".**
   Based on this evaluation, your retina physician will determine if/when surgery is recommended. If surgery is recommended, your physician will review your specific plan with you.

2. **If surgery is recommended, the day and time will be communicated to you following your evaluation. Our Surgical Coordinator will review additional details with you, such as your insurance coverage, the location of your surgery, and recovery process. Your surgical facility and surgeon will be determined based on urgency.**

3. **Retinal surgeries require very specialized equipment in a sterile operating room and cannot be performed in the clinic where you will be evaluated.**

4. **All surgical facilities are located in the Minneapolis / St. Paul area.**

   If you are traveling from outside the metro, you will need to make arrangements for overnight accommodations.

5. **You will need a driver, for travel to and from your evaluation.**

   Please ensure your driver does not leave until a "Plan of Care" is confirmed.

6. **If Surgery is performed, you will need someone to stay with you overnight.**

7. **DO NOT eat or drink anything 8 hours prior to surgery.**

   (Surgery could possibly be scheduled 1-2 hours following your evaluation.)

   Failure to comply with this requirement may result in the delay or postponement of your surgery.

8. **On the day following surgery, plan on being seen again for a Post-Op evaluation. Again, you will need a driver. This evaluation allows our doctors to check your eye pressure and rule out any evidence of infection.**

   After your Post-Op evaluation, you can schedule future appointments at the clinic most convenient for you.

For Locations and Contact Information, please go to:

www.RetinaMN.com