

LEDER RETINA

H. Alexander Leder, M.D.

Diseases and Surgery of the Retina, Macula and Vitreous

Name: _____

Address: _____ Apt/Unit: _____

City, State & Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Cell Phone: _____ Secondary Phone: _____

Email: _____

Gender: _____ Languages Spoken: _____

Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Race: ☐ White ☐ Black, African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Emergency Contacts:

Name of Person	Relationship to Patient	Phone
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_____	_____	_____
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If Patient is a Minor:

Name of Parent/Guardian	Relationship to Patient	Phone
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_____	_____	_____
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Release of Information

I authorize Dr. H. Alexander Leder and the staff of Leder Retina to release information concerning the status of my health care, information about findings resulting from my eye exam(s), my plan of treatment, as well as billing and appointment information with the following individuals.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information.

(PLEASE include your spouse, parents, siblings, adult children, close friend, guardian, your Emergency Contact, etc. – anyone we can speak with about you)

If they are not listed below, we are unable to speak to them regarding you, your appointments or your care!

Referring Physician

Office Phone

Primary Care Physician

Office Phone

Name of Person

Relationship to Patient

Name of Person

Relationship to Patient

Name of Person

Relationship to Patient**Signature** _____**Date** _____

Insurance Information:

Primary Insurance

Policy Number

Subscriber Name

Relationship to Patient

Subscriber's DOB

Subscriber's SSN

Secondary Insurance

Policy Number

Subscriber Name

Relationship to Patient

Subscriber's DOB

Subscriber's SSN

I hereby authorize my insurance benefit to be paid directly to Leder Retina for any services furnished to me. I acknowledge financial responsibility for non-covered services. I also authorize the physician to release any information required to process this claim.

Signature _____ Date _____

Patient Dilation Consent Form

Patient dilation is an important part of the complete eye exam. Dilation will make your pupil (the black part in the center of your eye) large so that Dr. Leder can get a better look at the back of the eye to check for any problems that can occur due to the following:

- **Systemic Diseases**, such as Diabetes, High Blood Pressure, Cancer, etc. that can affect the eyes without the obvious symptoms to the patient.
- **Physical Changes** in your eyes, such as Cataracts, Glaucoma, Retinal Detachments, etc. that can affect your vision.

The dilation will make reading things up close difficult, and make lights seem brighter than usual. This will last for 3-5 hours, although it can last longer in some people. Most people will be able to drive once their eyes are dilated, as long as they have sunglasses (which we can provide if you didn't bring any). However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver. There is no additional charge for having your eyes dilated.

Please note you will be dilated for all your visits.

I have read the above and give consent to have my eyes dilated.

Signature: _____

Date: _____

NOTICE TO OUR PATIENTS

Due to increasing costs and the complexity of regulations, we have found it necessary to charge our patients for some services.

Insurance Carriers do not cover these fees and therefore becomes the patient's responsibility. We must request payment at the time of service.

Non-Covered Services Include:

- **A fee of \$40.00 will be charged to the patient's account for appointments which are missed ("no-show"), cancelled or rescheduled without notifying this office at least 24 hours in advance.**
- **A fee of \$25.00 will be charged for completion of forms. Such forms include Disability, Life Insurance, Short Term Disability, FMLA, etc. Please leave the form with us and allow 7-10 business days for completion.**
- **Copies of Medical Records, requested by the patient: In accordance with Florida Administrative Code 64B8-10.003, the set price is \$1.00 per page for the first 25 pages, then 25 cents per page for the remaining pages.**
- **After hours non-emergency calls may be charged a \$25 fee. If your call is non-emergent, please call the office during regular business hours.**
- **Returned Checks: We will assess a fee on all checks that have been returned by our bank for "non-sufficient funds" per applicable state law. Payment of this fee must be made prior to your next appointment.**

Patients who repeatedly fail to provide the requisite notice prior to appointment cancellation may be discharged from the practice.

All cancellation or "no-show" fees MUST be paid before a new appointment can be scheduled.

Signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing **Leder Retina**. We are committed to the treatment, preservation, and advancement of your retina care. Please understand that payment of your bill is considered part of your retina care. The following is a statement of our Policy, which we require that you read and sign before being seen by one of our physicians.

Your Responsibility: You are financially responsible for the services we provide to you. As such, we require that the patient or legal guardian either pay or arrange for payment at time of service. As a courtesy to you, we will file a claim with your insurance plan(s). Please remember that your insurance benefits are a contract between you and your insurance carrier. If there is a discrepancy with payment of our claims, we may look to you for assistance in expediting our claims in a timely manner.

Non-Covered Service Condition: Since we are a specialty practice, some procedures that may be performed in your treatment plan could be deemed non-covered by your insurance plan. In the event that these services are determined non-covered, it is your responsibility to pay for the services rendered. Our patient financial counselors are available to review these out-of-pocket expenses with you prior to services being rendered.

Prior Balance: Patients with a balance from prior dates of service will be required to pay that balance in full before being seen by our physicians. If the prior balance cannot be paid in full, you will be asked to speak to our patient financial counselors to make payment arrangements based on our payment policy prior to being seen by one of our physicians. Prior balances must be resolved before the practice will provide new services.

Self-Pay Patients: Those who have no insurance or who elect to pay fee-for-service will be extended a discount from charges. You will be expected to pay for the balance, in full, at the time of service.

Returned Checks: We will assess a fee on all checks that have been returned by our bank for "non-sufficient funds" per applicable state law. Payment of this fee must be made prior to your next appointment. Collection Agency Prompt payment of patient balances is expected per the terms of this agreement. We will use an outside collection agency for patient balances as we deem necessary. Failure to resolve outstanding patient balances may result in discharge from care by our physicians.

I have read and understand the financial policy of **Leder Retina & Uveitis**. I agree and understand the terms and conditions of this policy and agree that any questions I have, have been answered by the patient financial counselors to the best of my understanding.

Signature: _____ **Date:** _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my Dependent) have insurance coverage with the carrier(s) given to the front desk staff and assign directly to **Leder Retina & Uveitis** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In Medicare assigned cases, the physician or supplier to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize medical or other information about me to be released to the Social Security Administration, its intermediaries, or its carriers in order to process a Medicare claim. I request that payment of authorized benefits be made on my behalf to the physician. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

If your insurance is an HMO, your HMO requires that your primary care doctor provide a referral to the physician who is providing your ophthalmology care. **It is your responsibility to obtain authorization in advance of your appointment (at least 24hrs.).** Your doctor may mail/fax it to our office or you may bring it to your visit. Contact us if you require any assistance in obtaining the authorization. We will be happy to help in any way possible. **If an authorization is not obtained from your insurance/primary care doctor prior to the delivery of care, we will expect you to accept financial responsibility for any charges.** You will be sent a bill from the billing office for physician services provided to you. I have read the statement above and I understand that I will be billed and am responsible for payment for the professional and facility fees for services provided to me in the event that my HMO does not authorize these services.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand I have the right to request and be provided with a Notice of Health Information Privacy Practices, which provides a complete description of health information uses and disclosures. I understand that I have the following rights and privileges.

The right to review the notice prior to signing this consent. The right to object to the use of my health information for directory purposes. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, **Leder Retina** will no longer use or disclose medical information about me for the reasons covered by my written authorization.

I understand that **Leder Retina** is unable to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me.

I further understand that if I choose to revoke my consent, **Leder Retina** may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

By signing this document, I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____