Retina Specialists
of Michigan

5030 Cascade Road SE
Grand Rapids, MI 49546
Phone (616) 954-2020

Patient Registration

Date: _____

PATIENT INFORMATION *(Please Print)*

NAME _____ PREFERS TO BE CALLED _____
FIRST MI LAST

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____
OK TO LEAVE A MESSAGE ☐ YES ☐ NO

DATE OF BIRTH _____ AGE _____ ☐ MALE ☐ FEMALE SS# _____-_____-_____

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED EMAIL ADDRESS _____

ORIGIN: ☐ HISPANIC / ☐ NON HISPANIC RACE: _____ PREFERRED LANGUAGE: _____

OCCUPATION _____ EMPLOYER _____ ☐ RETIRED

IF PATIENT IS A CHILD:
PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

ADDRESS _____ DATE OF BIRTH _____

GETTING TO KNOW YOU

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE # _____

POA _____ If applicable, please provide copy of legal papers.

DO YOU LIVE IN A TEMPORARY SKILLED NURSING HOME, REHAB CENTER, ETC.? TYPE OF FACILITY _____

NAME OF FACILITY _____ PHONE # _____

ADDRESS _____

ALTERNATE/WINTER ADDRESS & PHONE _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ☐ PATIENT ☐ OTHER

NAME _____ RELATIONSHIP _____ SS# _____-_____-_____

ADDRESS _____ PHONE # _____

MEDICAL INSURANCE

DO YOU HAVE MEDICAL INSURANCE COVERAGE? ☐ YES ☐ NO

PRIMARY INSURANCE

INSURANCE NAME _____

CONTRACT / ID # _____

EMPLOYER _____

SUBSCRIBER INFORMATION IF DIFFERENT THAN PATIENT

NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

SS# _____-_____- _____

SECONDARY INSURANCE

INSURANCE NAME _____

CONTRACT / ID # _____

EMPLOYER _____

SUBSCRIBER INFORMATION IF DIFFERENT THAN PATIENT

NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

SS# _____-_____- _____

Please turn over and sign

Statement of Financial Responsibility & Release of Information

Patient Name: _____ **DOB:** _____

Retina Specialists of Michigan (RSM) appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf; however, you are ultimately responsible for payment of your bill.

Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. We recommend you contact your insurance carrier and check into your coverage and benefits. Being referred to our office by another physician does not guarantee that your insurance will cover our services.

If your insurance plan requires you to pay a deductible and a co-pay for services rendered, you will be required to pay this at each visit upon check-in. You are also responsible for payment of any co-insurance as determined by your contract with your insurance carrier. We will bill your co-insurance balance to you.

Payment of your services is expected to be paid in full within 90 days of the date of service, unless other financial arrangements have been made. If you cannot pay your balance in full, we will provide you with information for a financing company. If payment is not received within the expected time frame, you risk having your account turned over to a collection agency.

If you are unable to keep your scheduled appointment, we ask that you give us at least 24 hours advance notice. If 24-hour notice is not given, you will be billed a $25.00 no show fee.

Patient Agreement: My signature below indicates I have read the above policy regarding my financial responsibility to Retina Specialists of Michigan and I agree to comply with all the above. I will be responsible for understanding information about my health insurance policy and providing such information to Retina Specialists of Michigan for correct billing. I will also be responsible for notifying Retina Specialists of Michigan of any changes in my health insurance status.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

Medicare Claims

I request that payment of authorized Medicare benefits be made on my behalf to Retina Specialists of Michigan, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____

Commercial/Medicaid Claims

I authorize Retina Specialists of Michigan to bill my insurance for services rendered, and I authorize my insurer to pay any benefits directly to Retina Specialists of Michigan the full and entire amount of bill incurred by me or the above-named patient.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____