Retina Center of Maine

Mark W. Balles, MD
195 Fore River Parkway, Suite 480
Portland, Maine 04102
Phone: 207-773-3938 Fax: 207-773-0801
www.retinamaine.com

Appointment Date: _____/_____/_____ @ _____: _____☐am ▫pm

Patient ID #: _____

Patient Demographics

Today's Date: _____/_____/_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name: _____ MI: _____ Last Name: _____ Suffix_____

Preferred First Name: _____ Sex: ☐Male ☐Female

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____

Address: _____ Apt#_____

City: _____ State: _____Zip Code: _____

Home # (_____) _____-_____ Work# (_____) _____-_____ Cell # (_____) _____-_____

Email:_____@_____.com

Employer: _____ Job Title: _____

Employment Status: ☐ Full ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐Widow

Ethnicity / Race: ☐Native American ☐Asian ☐Black or African American ☐White/ Caucasian ☐Other: _____

Preferred Language: _____

Emergency Contact: _____ Relationship: _____

Home # (_____) _____-_____ Work# (_____) _____-_____ Cell # (_____) _____-_____

Patient ID #: _____

Medical History Form: Part 1

Reason for Visit: _____

Onset of Symptoms: _____/_____/_____ Severity: ☐Mild ☐Moderate ☐Severe

Have you had any treatments to date: ☐Yes ☐No If yes, please explain:

If yes, please explain: _____

Who provided treatment: _____ Phone #: (_____) _____-_____

Medical Illnesses: ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ Cancer: Indicate type: _____ □ Radiation □ Chemotherapy

☐Other Illnesses: _____

Eye Diseases: ☐ Glaucoma ☐Cataracts ☐Retinal Detachment ☐Diabetic Eye Disease

☐ Other Eye Diseases: _____

List all prior eye surgery including Laser Eye Surgery / Treatment:

Provider Name	Surgery / Treatment	Phone Number

Does anyone in your ***immediate family*** have any of the following: If so, please indicate family member:

☐ Diabetes Relationship: _____

☐ Glaucoma Relationship: _____

☐ Cancer Relationship: _____

☐ Macular Degeneration Relationship: _____

☐ Retinal Detachment Relationship: _____

P**atient ID #:** _____

Medical History Form: Part 2

Providers – To aid in communications with your other health care providers, please provide the following

Heath Care Specialty	Name	Phone Number
Primary Care Physician		
Optometrist		
Diabetologist / Endocrinologist		
Cardiologist		
Oncologist		
Other:		
Other:		
Other:		

Medication - Please fill out completely INCLUDING eye drops / ointments

Medication Name	Dosage	Frequency

Are you allergic to any medications: ☐YES □ NO
If yes, please explain: _____

Pharmacy Name: _____ Phone #: (_____) _____-_____

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Financial Policy

Payment is due in full at the time service is rendered, including co-payments and deductibles. As a courtesy to our patients, we will bill your health plan for the services you have received with proof of insurance. Acceptable proof of insurance is a current health plan identification card containing all necessary billing information or appropriate internet verification. Patients who do not have health plan coverage will be expected to pay at the time of service.

Our Billing Staff will be glad to provide patients with an estimated fee for services prior to their examination. If additional charges would be required for treatment or diagnostic testing required, you will be advised of this during your visit.

If you have a worker's compensation claim, you must provide verification of worker's compensation and authorization for treatment prior to your appointment.

For your convenience, our practice accepts MasterCard, Visa, Discover, and American Express credit cards, personal as well as business checks, and cash payments. Checks returned for non-sufficient funds will be charged the bank's $25-dollar service fee. Overdue payments will be charged a 1.5% finance charge per month.

Delinquent accounts may be referred to a collection agency and may include additional collection fees added to your outstanding balance. If it becomes necessary to refer your account to collections, our understanding will be that you have chosen to discontinue your doctor patient relationship with our medical practice.

Patients may request our office to complete various forms for you such as short-term disability or family medical leave forms. Fees for providing this service is $50.00, we are glad to provide you with a copy of your medical record at no charge.

If you are unable to keep your scheduled appointment, please contact our office at least forty-eight (48) hours prior to your appointment to avoid a $50.00 missed appointment charge. This charge must be paid prior to being given a new appointment.

By signing below, I acknowledge that I have read and understand the Financial Policies of Retina Center of Maine.

Patient / Guarantor signature: _____ Date: _____

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Non – Covered Service Waiver

There are items and services for which your Health Plan will not pay for. Your Health Plan does not pay for all of your health care costs. Your Health Plan only pays for covered benefits. When you receive and item or service that is not a covered benefit under your Health Plan, you will be responsible for payment, personally or through any other insurance plan you may have.

The purpose of this waiver is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. The fact that your Health Plan does not pay or provide coverage for a certain services or items foes not meant that you should not receive it. There may be a good reason that your Provider has recommended it.

Before you make a decision, you may want to contact your Health Plan to determine whether the recommended item or services is a Covered Benefit.

You are being seen at Retina Center of Maine today on an emergency basis. There is a fee for emergency services in addition to the office visit. We believe this may not be a Covered benefit. It is anticipated that the estimated cost of the service or item is **$100.00**.

By signing this waiver, I acknowledge that if the above referenced item or service deemed Non – Covered by the Health Plan, which includes determining that the item or service is not Medically Necessary, I agree to be financially responsible for either the full amount or the balance after payment by the Health Plan should the Claim be denied or processed at a lesser Benefit level.

By signing this form, I also acknowledge that this was presented to me prior to receiving the services today.

Signature: _____ Date: _____/_____/_____

Patient ID #: _____

Health Insurance: Part 1

Please Provide Copies of ALL health insurance coverage

Primary Insurance

Primary Insurance: _____Effective Date: _____/_____/_____

If you have Medicare, are you or a spouse working? ☐Yes ☐No

Subscriber Name:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name: _____ MI: _____ Last Name: _____ Suffix_____

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____

Relationship: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy ID#: _____

Group #: _____ Group Name: _____

Secondary Insurance

Secondary Insurance: _____Effective Date: _____/_____/_____

Subscriber Name:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name: _____ MI: _____ Last Name: _____ Suffix_____

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____

Relationship: ☐Self ☐Spouse ☐Child ☐Other: _____

Policy ID#: _____

Group #: _____ Group Name: _____

Patient ID #: _____

Health Insurance: Part 2

If you have an HMO Insurance Plan, you MUST have a Referral from your Primary Care Physician. This is your responsibility to do BEFORE the date of your appointment. Failure to do so may make this visit non – covered.

I hereby authorize the release of information necessary to file a claim with my insurance carrier and assign benefits to the doctor indicated on the claim.

HIPPA: Health Information Privacy Policy Act

HIPPA: Health Information Privacy Policy Act prohibits the release of any information regarding your medical, personal, or financial status with our office. If you would like to ALLOW us to share information regarding your visits here, please list that person, or persons below:

Do Not list your health care providers in this area.

☐ DO NOT release my information to anyone.

Contact: _____ Relationship: _____

Home # (_____) _____-_____ Work# (_____) _____-_____ Cell # (_____) _____-_____

Contact: _____ Relationship: _____

Home # (_____) _____-_____ Work# (_____) _____-_____ Cell # (_____) _____-_____

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Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

I have been provided with a copy of Retina Center of Maines Consent to Use and Disclosure of Protected Health Information and Notice of Privacy Practices.

I understand that if I have any questions about the consents of the Retina Center of Maines Consent to Use and Disclosure of Protected Health Information and Notice of Privacy Practices, or if I wish to have a copy of this consent, I may ask the office staff or Privacy Contact for the practice.

Signature: _____ Date: _____/_____/_____