ARK-LA-TEX RETINA CONSULTANTS
Wilson B. Baber, M.D., F.A.C.S
(318) 221-3403
(903)248-2300

PATIENT REGISTRATION

Patient's Last Name:_____First:_____Middle:____

Mailing Address: _____

City:_____State:_____Zip Code:_____

Home Phone:_____Day Phone:_____

Cell Phone: _____E-Mail:_____

Date of Birth: Month_____Day_____Year_____

Social Security Number:_____-_____-_____

Marital Status: Single Married Divorced Widowed

Gender: Male Female

Height_____Feet_____Inches Weight_____lbs

Preferred Language: English Spanish Other

Race: Caucasian African-American Hispanic Native-American Other

Occupation: _____

Emergency Contact Name: _____Relationship:_____

Emergency Contact Phone Number: _____

Emergency Contact Address:_____

Patient's Family Physician_____

Preferred Pharmacy: _____Telephone:_____
Address:_____City_____State_____

Referred By:_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name	**Relationship to Patient**	
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name	**Relationship to Patient**	
Social Security Number	Date of Birth	Employer

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **Ark-La-Tex Retina Consultants, L.L.C.** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity: **Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to **Wilson B. Baber, M.D. L.L.C., dba Ark-La-Tex Retina Consultants, L.L.C.**

_____ Signature of the Patient or Patient Representative

Medical History

1. Have you ever been treated for any medical condition
   YES NO Diabetes
   YES NO High Blood Pressure
   YES NO Stroke
   YES NO Arthritis
   YES NO Asthma/Emphysema
   YES NO AIDS
   YES NO Cancer (including skin cancer)
   YES NO Heart Disease
   YES NO Heart Attack
   YES NO Tuberculosis (TB)

2. Have you ever been hospitalized or had any type of surgical procedure performed on you? Yes_____ No_____
If Yes, Please
list_____

_____

3. Are you presently taking any medication? Yes_____ No_____ If Yes, Please
List_____

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4. Are you allergic to any medications? Yes_____No_____ If Yes,
Please List_____

EYE HEALTH HISTORY (Please check all diseases and symptoms that apply to you)

Cataract____ Glaucoma_____ Macular Degeneration_____ Diabetes_____Floaters_____

Retinal Detachment_____ Retinal Tears_____ Previous cataract SX_____ Previous Injury/Trauma_____

REVIEW OF SYSTEMS Do you currently have any of the following problems? **(If Yes, Please Explain)**
Y N 1. Chronic fever, unexpected weight loss/gain, fatigue, blood disorders:_____
Y N 2. Ear/Nose/Throat problems, hearing loss, sinus problems, sore throat:_____
Y N 3. Heart problems, chest pain, irregular heartbeat, pacemaker:_____
Y N 4. Respiratory problems, shortness of breath, wheezing, coughing:_____
Y N 5. Gastrointestinal problems, heartburn, abdominal pain, diarrhea, vomiting:_____
Y N 6. Urinary problems, kidney disease, kidney stones, pain, discomfort, blood in urine:_____
Y N 7. Skin problems, rashes, excessive dryness:_____
Y N 8. Musculoskeletal problems, muscle aches, arthritis, joint pain, swollen joints:_____
Y N 9. Neurological problems, numbness, weakness, headaches, paralysis, dizziness:_____
Y N 10. Psychiatric problems, depression, anxiety:_____
Y N 11. Are you currently pregnant? If Yes, how many months?_____
Y N 12. Do you currently use tobacco? If yes, How many packs per day_____and for how many years_____?
Y N 13. Do you currently consume alcoholic beverages? If Yes, how often?_____
Y N 14. Do you exercise regularly? If yes, what type of exercise?_____

FAMILY HISTORY Does anyone in your family have a history of medical or eye disease? Explain and check any that apply:
List Family Members
Y N Glaucoma_____
Y N Cataracts_____
Y N Diabetes_____
Y N High Blood Pressure_____
Y N Macular Degeneration_____
Y N Heart Disease_____

INFORMATION REGARDING DILATING EYE DROPS
ARK-LA-TEX RETINA CONSULTANTS, L.L.C.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Wilson Baber and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____

Print Name

_____

Witness Signature Date

A. Notifier: ARK-LA-TEX RETINA CONSULTANTS, L.L.C.

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

OFFICE AND FINANCIAL POLICIES

ARK-LA-TEX RETINA CONSULTANTS, L.L.C.

Thank you for choosing our practice. This agreement is provided to you to clarify our payment policies. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you.

Insurance: Please bring your insurance and a picture ID with you at the time of your appointment.

We are members of most, but not all, insurance plans. **You are responsible for verifying if we are participating providers for your specific plan**. Your insurance carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us with a written waiver from your insurance carrier specifically authorizing this practice to waive this requirement.

You are responsible for any co-insurance, deductibles, as well as non-covered services considered non payable by your insurance carrier where following the state's required time limitation for paying health care claims. You will receive a statement from our office/billing service indicating what your insurance has paid. Any balance remaining is due upon receipt.

Claims submission: We will submit your claims to your insurance company on your behalf and we will, within reason, attempt to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Coverage changes: Insurance companies have very strict requirements with regard to filing deadlines for reimbursement of claims. Please notify us immediately of any insurance changes. If your insurance company does not pay your claim in 90 days, the balance may automatically be billed to you.

Medicare: We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved charged amount and the amount Medicare pays and, you're deductible of course. If you have supplemental insurance, we will bill them directly for you.

HMO or POS: Regarding insurance plans where we participate as a provider, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services from another provider, please bring that referral with you. **It is your responsibility to know your insurance requirements.** Any services received without a referral or proper authorization will be your responsibility.

No Insurance/Self Pay: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our office.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive required information from your employer before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims may become your financial responsibility.

Payment: We accept cash and checks only

All billing questions should be directed to PracticeMax: 318-424-5449

Disability or insurance forms: There will be a charge of $15.00 - $35.00 for the completion of medical forms. Charges are based on the number of pages and complexity of information requested. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing.

Cancelled appointments: WE REQUIRE AT LEAST A 24 HOUR CANCELLATION NOTICE. THIS WILL ALLOW US TO PROVIDE THAT TIME SLOT TO ANOTHER PATIENT. THERE IS A PENALTY FEE OF $25.00 IF YOU FAIL TO CANCEL AN APPOINTMENT. AND A $50.00 PENALTY FEE IF YOU FAIL TO CANCEL AN OFFICE PROCEDURE.

Medical records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release. Please allow 7-10 days for us to copy your records. If you wish for your records to be mailed, there may be an additional fee to cover the mailing costs. You may be charged for additional copies of your medical records the rates are charged within Louisiana state statues.

Return checks: A $25.00 charge will be added to your account for any check returned by your bank for any reason.

Financial Policy Agreement: My signature below indicates that I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information above and have completed the demographic and health history forms. I certify that this information is true and correct to the best of my knowledge. I will notify the practice of any change in my health status or demographic / insurance information.

Signature_____Date_____