Virata Retina Center
150 Professional Court Suite A
Lafayette, IN 47905

Phone: 765-573-8462
Fax: 765-767-4818

VIRATA RETINA CENTER
Specialized Eye Care Since 2001

## NEW PATIENT INFORMATION

First Name: _____ MI:____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ /_____/_____

Address: _____ Apt/PO Box_____

City: _____ State: _____ Zip: _____

Phone number : _____-_____-_____ Preferred phone: _____ Home _____Cell

Email: _____ @_____

Social Security Number: _____ -_____-_____

Employed:_____ Retired: _____ Unemployed:_____

Employer: _____ Occupation: _____

## Demographics

**Gender**: ___ Male ___ Female **Marital Status**: ___ Married ___ Single ___ Other/Widow

**Preferred Language**:___ English ___ Spanish ___ Other:_____

**Race**: ____ White _____ Black/African American ____ Asian _____American Indian

___ Native Hawaiian/ Or other Pacific Islander

**Ethnicity**: _____ Non Hispanic/Latino ____Hispanic/Latino _____ Other:_____

## Your Physician Contacts

Family Doctor/ NP: _____City/State/Organization_____

Eye/Referring Doctor: _____ City/State/Organization_____

Cardiologist: _____ City/State/Organization_____

Endocrinologist: _____ City/State/Organization_____

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# Permission to discuss your health information

I give permission to **Virata Retina Center LLC** to discuss the following medical and billing information about me to the person(s) below. Which may include:

- Scheduling/appointment information
- Medical information, including my symptoms, diagnosis, medication, and treatment plan
- Lab/test results
- Billing and payment information
- **___I do not want anyone discussing my health information**

| Name | Phone Number | Relationship to you |
|---|---|---|
| | | |
| | | |
| | | |

## Missed or Rescheduled Appointments

No-show and late cancelations represent a cost to us, to you and other patients who are also needing appointments. Cancellations are requested **24 hours** prior to your appointment. We reserve the right to charge $40 for No-Shows/ late cancelled appointments. Multiple no shows can result in termination from Virata Retina Center LLC.

## Eye Dilation

For your first appointment with Dr. Virata, **both of your eyes will be dilated for the exam. Depending on which eye(s) are being treated, future appointments will result in dilation of eye(s) being treated.** You may bring a guest to your appointment to drive you home as dilation can cause you to feel unsafe behind the wheel. Dilation can cause the following: blurred vision, inability to read and/or light sensitivity.These symptoms will diminish after the Dilation drop wears off, timing can vary between patients. Please be aware and cautious with walking, use of stairs and stepping on/off of curbs.

## Appointment Reminders:

How would you like your appointment reminder?

___ Text Message ___ Phone call ___Email

Phone number: _____- _____-_____ email: _____

Person confirming the appointment: _____

* You will receive 2 appointment reminders. First reminder will be 7 days prior and the second reminder will be 2 days prior to your appointment. **Please confirm!**

**I have read and understand the statements above regarding: My health information, Missed/Rescheduled appointments, Eye Dilation and appointment reminders.**

**Patient signature**:_____ **Date:**_____

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## Medical Consent:

I, the undersigned, being the person whose name appears hereafter designated as patient or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctor and staff of Virata Retina Center ("Doctor Office") to (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by a member of my doctor's staff as well as by the doctor himself and this routine work-up often include the instillation of eye drops for various reasons - such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, technicians and agents and employees of the Doctor's Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here DOES NOT extend to initiation of any oral or IV medication nor any surgical procedures, injections or lasers performed whether in the office or at a surgical facility. Separate consent must be obtained for any of these procedures.

## RELEASE OF INFORMATION

The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release and share copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier (s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request that my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

## OFFICE VISITS & DIAGNOSTIC TESTING

During your initial and follow-up office visits there may be additional charges for special tests or procedures that are necessary for your eyes' health. Examples of these tests include OCTs and ocular photography.

## DRUGS AND INJECTIONS

We require a signed Patient Authorization and Notification (PAN) form before receiving an injection of Lucentis, Eylea, Ozurdex, or Iluvien.

- If you are insured and have a covered indication you should be covered. However, you may have some out of pocket expenses depending on your insurance benefits, deductibles, etc.
- You may qualify for a drug assistance program. Please ask.
- If you are uninsured or the indication is off label you will be expected to pay for the cost of the drug at the time of service. Please ask the Front Desk Staff or call our Billing Office to obtain coverage and cost information.
- Avastin does not qualify for a drug assistance program. If you are responsible for the cost of Avastin payment in full is required at the time of service.

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## CLAIM FILING

As a courtesy, the Virata Retina Center will bill your primary and secondary insurance carrier. However, the payment for the service you receive is ultimately your responsibility and we will not "hold" a claim or balance due pending an insurance dispute. We will ask for your insurance card at each visit in order to ensure we have the proper information to bill your insurance company. We expect your insurance carrier to pay us within sixty days from the date of your visit. If your insurance does not pay us within the sixty day period we will bill you for the services you received, and it will be your responsibility to contact your insurance company regarding payment. It is also your responsibility to understand the details of your individual insurance plan. **Should your insurance plan require a referral from your family doctor you must obtain it before seeking our service. If you do not obtain the proper referrals or authorization, we will bill you directly and expect full payment from you.** You will be responsible for all out-of-network fees and penalties unless these are discussed with our staff prior to your visit or surgery.

## PAYMENT POLICIES

All co-pays and deductibles are due at the time of service. If your out-of-pocket or deductible is not met, you should anticipate paying for charges in full up to the deductible and/or out of pocket amount at the time of service. If you cannot pay the full amount, you will be required to have a credit card on file, or you be required to pay a deposit of $200.00. Please refer to the payment schedule below if your balance exceeds $200.00. If you do not have insurance or do not have your insurance cards we require a $200 deposit and you will be billed for the remainder, or we may reschedule your appointment. If you are going to have surgery you will speak with one of our surgical schedulers, who will explain your surgery and the methods of payment. If you do not have insurance, or if the care you are to receive is not covered by your insurance provider, we require payment prior to the surgery. **If a patient needs medical attention with a pending settlement or lawsuit, the patient will be considered a cash patient and will need to pay for any exam or procedures upfront**. We accept checks, money orders, and credit cards. There is a $35 service charge for all returned checks. Other payment plans will be available to you under extreme circumstances - please explain your concerns to our staff at the time you speak with them

## PAYMENT SCHEDULE

Although we expect payment in full at the time of service we are willing to accept a reasonable payment plan as follows if you are unable to pay the full amount at the time of service.

- $201.00 to $1,000.00: 3 months to pay $1,001.00 to $2,000.00: 6 months to pay
- $2,001.00 to $3,000.00: 9 months to pay $3,001.00 plus: 12 months to pay

## COLLECTION POLICY

If your account becomes delinquent and you have made no attempt to pay your bill or contact us we will turn your account over to an attorney or a collection agency. You agree to pay: (a) cost of collections in the amount of $25 if your account is forwarded to collections. If your account is forwarded to a collection agency for collections; (b) reasonable attorneys' fees that are incurred in the collection of your account whether or not legal proceedings are instituted; (c) court cost; and (d) interest at the unpaid balance of the amount at the statutory rate from the date it is turned over to the collection agency until paid in full.

## CONTACTING OUR BILLING DEPARTMENT

You may call the following Billing Department staff member for assistance regarding the bills you receive from the Virata Retina Center.

**Patient Billing Questions 1-765-227-3185**

All payments for services provided by Virata Retina Center should be made payable to: **Virata Retina Center LLC** and mailed to: Virata Retina Center LLC
150 Professional Court Suite A
Lafayette, Indiana 47905

**I have read and understand the Virata Retina Center LLC General & Financial Policies.**

Patient Signature: _____ Date: _____

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**MARK ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:**

☐ Loss of Vision ☐ New Floaters ☐ Distortion ☐ Eye Pain/Soreness
☐ Blurred Vision ☐ Flashes of Light Which Eye(s) is bothering you? :_____

**CHECK ALL MEDICAL DIAGNOSES THAT APPLY TO YOU, BOTH PRESENTLY AND IN THE PAST:**

☐ Alzheimer's ☐ COPD ☐ Heart Attack ☐ Anemia ☐ Congestive Heart Failure
☐ Kidney Disease ☐ Anxiety ☐ Dementia ☐ Leukemia ☐ Arthritis ☐ Depression
☐ Lupus ☐ Arrhythmia ☐ Diabetes-Type 1 ☐ Diabetes Type 2 **What is your A1C?**
_____
☐ Migraines ☐ Asthma ☐ Emphysema ☐ Bleeding Disorder ☐ GERD/Reflux
☐ Thyroid Disorder ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke

**EYE HISTORY:**

☐ No Significant History ☐ Bell'sPalsy ☐ Glaucoma ☐ Ocular Migraines ☐ Cataract
☐ Herpes Simplex ☐ Retinal Detachment ☐ Choroidal Nevus (mole) ☐ Iritis
☐ Retinal Vein Occlusion ☐ Choroidal Melanoma ☐ Lazy Eye (amblyopia)
☐ Retinal Artery Occlusion ☐ Diabetic Retinopathy ☐ Macular Degeneration
☐ Retinal Tear ☐ Double Vision ☐ Macular Hole ☐ Macular Pucker
☐ Retinal Injections ☐ Dry Eye Syndrome ☐ Macular Pucker ☐ Retinal Laser
☐ Other: _____

**EYE SURGERIES:**

☐ Cataract surgery: **L / R or Both** ☐ Glaucoma surgery: **L / R or Both**
☐ Corneal surgery **L / R Both** ☐ Laser surgery **L / R or Both**
☐ Eyelid surgery **L / R or Both** ☐ LASIK **L / R or Both**
☐ Eye muscle surgery **L / R or Both** ☐ Retinal surgery **L / R or Both**

**Surgical History**:

☐ Appendectomy ☐ Gallbladder ☐ Hernia Surgery ☐ Heart Surgery:_____
☐ Knee **L / R or Both** ☐ Shoulder **L / R or Both** ☐ Hip **L / R or Both**
☐ Carpal Tunnel / Trigger Finger Release **L / R or Both** ☐ Tonsillectomy & Adenoidectomy
☐ Partial or Total Hysterectomy ☐ C-section ☐ Tubal Ligation
☐ Other:_____

**Immunizations:**

Flu Shot (previous or current season? ☐ YES ☐ NO
Pneumonia Vaccine? ☐ YES ☐ NO
Covid Vaccine(s)? ☐ YES ☐ NO

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**FAMILY HISTORY: PLEASE SPECIFY WHO HAS THESE DIAGNOSES**

-( M-Mother) -(F-Father) - (B-Brother) -(S-Sister)
-(MGM- Maternal Grandmother) -(PGM Paternal Grandmother)
-(MGF- Maternal Grandfather) -(PGF- Paternal Grandfather)

| | | |
|---|---|---|
| _____Blindness | _____ Diabetes | _____ Retinal detachment/tear |
| _____ Cataract | _____ Heart Attack | _____ Macular degeneration |
| _____ Glaucoma | _____ Stroke | _____ Thyroid Disease |
| _____ Cancer | _____ High Blood pressure | _____ My family is healthy |

**SMOKING HISTORY:**
Smoker _____ Former Smoker ___ Never Smoker_____ **ALCOHOL USE:**

Packs per day: ____ Quit (year): _____ Daily____ Social____

Former____ None____

**Daily Medications (Including Over the Counter)**

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| | | | |
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**Medicated Eye Drops** _____ **I do not take any Medicated Eyedrops**

| | |
|---|---|
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| | |

**Medication Allergies:** **No Known Medication Allergies** _____

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