# RETINA – VITREOUS ASSOCIATES OF FLORIDA

Diabetic Retinopathy • Macular Degeneration • Macular Hole Macular Pucker • Uveitis
Retinal Vascular Occlusion • Retinal Detachment • Pediatric Retina • Ocular Tumors

Scott E. Pautler MD
Steven M. Cohen MD
Karina Billiris Findlay MD
David A. Eichenbaum MD


**DATE:** _____

**PATIENT'S NAME:** _____ **DOB:** _____

## GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

**CONFIDENTIALITY:**
In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

**FINANCIAL POLICY:**
I authorize Retina Vitreous Associates of FL to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. Late charges of 2% will be assessed against the outstanding balance for any amount owed over 60 days. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Retina Vitreous Associates of FL to release medical information for insurance purposes. I authorize payment to be made directly to Retina Vitreous Associates of FL if an assignment is indicated by my insurance company. As a courtesy, Retina Vitreous Associates of FL will contact insurance companies for authorization for services required. Retina Vitreous Associates of FL is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

Patient/Guardian Initials: _____

**FAILURE TO FOLLOW PHYSICIAN ORDERS:**
"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness or failure to attend follow-up appointments. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____

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**FORM COMPLETION POLICY:**
The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires Retina Vitreous Associates of FL to implement the following charge policy for all forms.

- Completion of one (1) form page = $25
- Completion of two (2) or more form pages = $50 (maximum charge)

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms.

When your forms are completed, Retina Vitreous Associates of FL will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Retina Vitreous Associates of FL will collect the related fee via cash, money order, personal check, credit card, or debit card (MasterCard or Visa logo).

Patient/Guardian Initials: _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**
As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. (Dated April 14, 2003)

I have received a copy of Retina Vitreous Associates of FL's Notice of Privacy Practice.

Patient/Guardian Initials: _____

**ACKNOWLEDGEMENT OF IDENTITY THEFT PREVENTION AND DETECTION AND RED FLAG RULE PRACTICES:**
By signing this notice you have acknowledged receipt of our Notice Red Flag Rule Compliance. (Dated May 1, 2009)

I have received a copy of Retina Vitreous Associates of FL's Notice of Red Flag Rule Compliance.

Patient/Guardian Initials: _____

**PATIENT'S SIGNATURE:**

Patient/Guardian Signature: _____ Date: _____