Pooja Garg, M.D.
4515 Wiles Rd., Suite #201
Coconut Creek, FL 33073

RETINA
EYE SPECIALISTS

Ph: (954) 633-8202
Fax: (954) 586-4196
www.RetinaEyeDoc.com

Patient Registration

Name: _____

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____ Mobile Carrier: _____

Email Address: _____

Preferred Language: _____ Occupation: _____

How did you hear about us? _____

Referring Physician: _____

Primary Care Physician: _____

Primary Insurance:

Insurance Type: _____ Insurance Member ID#: _____

Holder Name: _____

Holder DOB: _____ Social Security #: _____

Holder Address: _____

City: _____ State: _____ Zip Code: _____

Holder phone #: _____ Holder email: _____

Secondary Insurance:

Insurance Type: _____ Insurance Member ID#: _____

Holder Name: _____

Holder DOB: _____ Social Security #: _____

Holder Address: _____

City: _____ State: _____ Zip Code: _____

Holder phone #: _____ Holder email: _____

Emergency Contact:

Name: _____

Relationship: _____ Phone #: _____

Preferred Pharmacy:

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cross-Streets: _____

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HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

o My complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) OR

o My complete health record, as above, with the exception of the following information:

- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Other (please specify _____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

o All past, present, and future periods OR

o Date or event: _____
unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____ _____
Patient Name Date

▶ _____ _____
Patient Signature Date

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Notice of Policies and Billing Practices

Private Accounts
The offices of Dr. Pooja Garg will file insurance claims on your behalf if you present your insurance card(s) at the time of your appointment. Exceptions to this policy include out-of-state Medicaid. Copays, coinsurance, and deductibles as defined by your insurance carrier, are due at the time of service. Accounts that are unpaid after 90 days are turned over to a collection agency.

Payment of your co-insurance and/or co-payments, as defined by your insurance carrier, is required at the time of service**.** If your insurance company requires a **REFERRAL/AUTHORIZATION**, this **MUST BE RECEIVED PRIOR TO YOUR VISIT**. Patients without prior authorization from the insurance company/PCP will be asked to pay in full at the time of service. Uninsured patients are required to pay in full for services rendered at the time of appointment. The offices of Dr. Pooja Garg will not be responsible for negotiating a settlement or disputed claim with your insurance company.

Liability Accounts
When you have been involved in an accident, your health insurance may be filed, provided they make payment without waiting for all other insurance to be exhausted. Premises medical coverage may pay your medical bills as they are incurred if you were injured on the property of a business or homeowner. This information must be supplied at the time of your appointment. If auto, healthy, or premises medical insurance coverage information is not available, you will be given the necessary forms to file your own claim; however, payment in full will be required at the time services are rendered.

Authorization
Prior to your visit, your employer's worker's compensation carrier must call this office to establish your injury or occupational disease as a recognized work-related problem. Without this verification, you will be responsible for payment of your account. Laws governing work-related injuries require your physician to submit a report of your progress following each visit to your employer, insurer, and/or rehabilitation representative. In the event the employer or insurer denies you verification, your claim can be filed with your private health insurance. As a private account, co-payment would be expected at time of visit. **If you have any questions, please contact our office at (954) 633-8202 or the Billing department at (786) 621-3900 // (888) 553-8333.**

My signature below represents that I have read and understand these policies of the offices of Pooja Garg, MD. I also agree to make available information required and necessary for Retina Eye Specialists to file insurance claims on my behalf, and that ultimately, I am responsible for my account, and failure to make payment on a timely basis may result in collection actions

▶ _____ _____
Patient Signature Date

<u>Authorization to release information and pay benefits to physician</u>
I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Retina Eye Specialists for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or their insurance companies and its agents any information needed to determine these benefits payable for related services.

▶ _____ _____
Patient Signature Date

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Medication

Are you allergic to any medications? ☐ Y ☐ N If YES, please specify _____

**** Please include any eye drops ****

Name of medication	Dosage (mg)	Frequency

Tech Signature	Updates	Date Checked

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Patient History Form

Review of Systems: Do you currently have any of the following problems? If Yes, please specify and explain.

1. Constitutional (fever, weight loss, other)	☐ Yes ☐ No	
2. Eyes (glaucoma, cataract, lazy eye, retina problems, other)	☐ Yes ☐ No	
3. Ear/Nose/Throat (hearing loss, sinus problems, sore throat)	☐ Yes ☐ No	
4. Cardiovascular (heart problems, chest pain, irregular heartbeat, cholesterol)	☐ Yes ☐ No	
5. Respiratory (asthma, shortness of breath, wheezing, coughing)	☐ Yes ☐ No	
6. Gastrointestinal (heartburn, abdominal pain, irritable bowel syndrome, acid reflux)	☐ Yes ☐ No	
7. Genitourinary (urinary problems, kidney problems)	☐ Yes ☐ No	
8. Integumentary (skin rash, excessive dryness)	☐ Yes ☐ No	
9. Musculoskeletal (muscle aches, joint pain, swollen joints)	☐ Yes ☐ No	
10. Neurological (numbness, weakness, headaches, paralysis, stroke)	☐ Yes ☐ No	
11. Hematologic/Lymphatic (blood disorders, leukemia)	☐ Yes ☐ No	
12. Allergic/Immunologic (hay fever, allergies)	☐ Yes ☐ No	
13. Endocrine (thyroid problems, diabetes)	☐ Yes ☐ No	
14. Psychiatric (depression, anxiety, other)	☐ Yes ☐ No	

Have you recently experienced any of the following symptoms? Please check all that apply.

- ☐ Headaches
- ☐ Migraines
- ☐ Double Vision
- ☐ Blurry Vision
- ☐ Loss of Vision
- ☐ Dizziness
- ☐ Loss of Balance

Family History:

Do any medical or eye diseases run in your family? If YES, please note the relationship.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Other
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment

Social History:

Do you use tobacco? If YES, how much? _____

Do you drink alcohol? If YES, how much? _____

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Release of Information and Certification

I authorize the release of complete medical information to my referring physician.

I authorize the release of complete medical information to any physician or other health care provider to whom I am referred by my physician.

▶ _____ _____
Patient Signature Date

By signing below, I certify all information is true and correct to the best of my knowledge.

▶ _____ _____
Patient Signature Date

_____ _____
Physician Signature Date