VRMNJ VITREOUS RETINA MACULA SPECIALISTS OF NEW JERSEY

## NEW PATIENT REGISTRATION/ *REGISTRO DE NUEVOS PACIENTES*

**First Name/*Primer Nombre*:**_____ **Last Name/*Apellido*:**_____ **Middle Initial:**_____
**DOB/*Fecha de Nacimiento*:**_____/_____/_____ **SS#** *(for insurance purposes)*:_____-_____-_____

**Sex assigned at birth/*Género*:** ○ M ○ F ○ Decline to specify/*Niego a especificar*
**Pronouns/*Pronombres*:** ○ He/him/his *(él/él/su)* ○ She/her/her *(ella/ella/ella)* ○ They/them/their *(ellos/ellos/sus)*
○ Decline to specify/*Niego a especificar*

**Preferred Language:** ○ English ○ Español ○ Other:_____

**Race:** ○ Asian ○ Black and/or African American ○ White/Caucasian ○ American Indian/Alaska Native ○ Decline to specify
**Ethnicity:** ○ Hispanic/ Latino ○ Not Hispanic/ Latino ○ Decline to specify/*Niego a especificar*
**Marital Status:** ○Single/*Soltera(o)* ○Married/*Casada(o)* ○Divorced/*Divorciada(o)* ○Separated/Separada(o) ○Widowed/Viuda(o)

**Address/*Dirección*:**_____ **Apt #:**_____
**City/*Ciudad*:**_____ **State/*Estado*:**_____ **Zip/*Código Postal*:**_____
**Home #/# *tele. (casa)*:**_____ **Cell/*Celular #*:**_____ **Work #/# de Trabajo:**_____
**Email/*Correo Electrónico:***_____

**Referring Ophthalmologist/ Optometrist *(Doctor que le refirió)*:**_____
**Address/*Dirección*:**_____ **Phone#/*Numero Tele.*:**_____
**Primary Care Physician/*Doctor Primaria*:**_____
**Address/*Dirección*:**_____ **Phone#/*Numero Tele.*:**_____

**Emergency Contact/*Contacto de Emergencia*:** _____ **Phone#/*Numero Tele.*:**_____
**Relationship to Patient/Relación al Paciente:**○ Spouse/*Esposo(a)* ○ Partner/*Pareja* ○ Parent/*Padre/Madre*
○ Sibling/Hermano(a)○ Child/*Hijo(a)* ○ Other/*Otro*:_____

### Insurance Information/*Información del Seguro Médico*

****PLEASE FILL OUT COMPLETELY & ACCURATELY****
****POR FAVOR DE LLENAR TOTALMENTE****

**Primary Insurance Name/*Nombre del Seguro Primario*:**_____
**Guarantor's Name** *(Policyholder)*/***Persona Principal del Seguro*:** _____ ○ Self/*Usted*
**Address/*Dirección*:**_____ ○ Same as above/*La misma que arriba*
**DOB/*Fecha de Nacimiento*:**_____ **Relationship to Patient/Relación al Paciente:**_____

**Secondary Insurance Name/*Nombre del Seguro Secundaria*:**_____
**Guarantor's Name** *(Policyholder)*/***Persona Principal del Seguro*:** _____ ○ Self/*Usted*
**Address/*Dirección*:**_____ ○ Same as above/*La misma que arriba*
**DOB/*Fecha de Nacimiento*:**_____ **Relationship to Patient/Relación al Paciente:**_____

○ SELF PAY/NO SEGURO MÉDICO

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**Notice of Privacy Practices/ Financial Policy**
I have received a copy of VRMNJ's notice of privacy practices effective 1/1/22. I, the undersigned, authorize VRMNJ to discuss my private medical information with the following people:

Name: _____ Name:_____
Name: _____ Name:_____
Name: _____ Name:_____

We are committed to provide you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide medical and surgical ophthalmological-retinal care to our patients. If you have medical insurance requires a referral to be seen by a specialist, you must obtain the referral in order to be seen or you may be asked to pay out of pocket for the visit prior to the exam or to reschedule your appointment until you're able to obtain an insurance referral. On occasion, our staff may be able to help you obtain the insurance referral for your visit, however this is the patient's responsibility.

There is a no show fee of $25 if you do not reschedule or cancel your appointment before the day of your scheduled appointment.

**Uniform assignment of benefits and release of information statement**
I hereby assign or transfer payment benefits made to me or on my behalf to Vitreous Retina Macula Specialist of NJ (VRMNJ) for any services furnished to me by this practice. I further agree that I am responsible for payment of charges incurred by me that are outside the scope of my insurance coverage or for which my insurance company has paid me.

I hereby authorize Vitreous Retina Macula Specialists of NJ (VRMNJ) to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If I am a medicare patient, I further authorize release to determine benefits payable to related services. I understand of my account becomes delinquent at any point, my account will be sent to a collection agency. I authorize VRMNJ to leave voicemails on my home/cell phone and to send me emails about appointments, collection of any balances or any other important communications.

**Patient or Guardian Signature: X**_____ **Date***(Fecha)*: _____
*(Firma del Paciente)*

**Print Name** *(Imprimir Nombre)*:_____

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**Consent for use and disclosure of protected health information (HIPAA)**

I, the undersigned, acknowledge receipt of the current effective Notice of Privacy Practices. This consent for use and disclosure of Privacy Practices. I have the right to review the Notice of Privacy Practices effective 1/1/2022 prior to signing this consent. VRMNJ reserves the right to revise its notices of Private Practices at any time. A revised Notice Privacy Practices may be obtained by forwarding a written request to VRMNJ. With this consent VRMNJ may call my home and other alternative location and leave a message on voicemail or in person reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory test results among others.

I hereby give my consent for VRMNJ to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Additionally, my information may be used to determine if I am a candidate for any research studies being conducted at VRMNJ under the supervision of the doctors in the practice. The Notice of Privacy provided by VRMNJ describes such uses and disclosure completely.

With this consent, VRMNJ may mail to my home or other alternative location items to assist the practice carry out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential” as well as the use of my email address to contact me in regards to changes in business hours, appointment information and introduction of new services provided by the practice.

I have the right to request that VRMNJ restrict how it uses or discloses my PHI to carry out TPO for which I must submit my written request to the HIPAA compliance office at VRMNJ.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, or later revoke it. VRMNJ may decline to provide treatment to me.

**Patient or Guardian Signature: X**_____ **Date***(Fecha)*: _____
*(Firma del Paciente)*

**Print Name** *(Imprimir Nombre)*:_____

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**Consent for Telemedicine Services**

Telemedicine involves the use of electronic communications (telephone, computer, etc.) to enable healthcare providers (doctors, nurses, physician assistants, and others) at a different location from the patient to share medical information with the patient for the purpose of improving access to patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices, sound and video files

The electronic systems used will attempt to incorporate security protocols to protect the confidentiality of patient identification, imaging data, and will include measures to safeguard the data to ensure its integrity against corruption.

Expected benefits include:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information from a distant site.
- Limiting the spread of COVID-19 and other communicable diseases.
- Ability to obtain consultation from a distant medical specialist without traveling.
- Conversation of personal protective equipment (PPE) such as gloves and masks to reduce shortages for healthcare providers.
- Allow medical evaluation and management of patients who are unable to travel.

As with any medical procedure, there are risks associated with the use of telemedicine. The risks include but may not be limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the healthcare provider. For instance, certain parameters of the eye exam cannot be tested remotely, such as eye pressure. In addition, there may be poor resolution of images. This may cause a delay in medical evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

**Patient's acceptance of risks**

By signing this form, I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine will be disclosed to researchers or other entities without my consent. I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment. I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners located somewhere else including out of state. I understand that no results from the use of telemedicine can be guaranteed or assured. I, the undersigned, authorize the doctors of VRMNJ to use telemedicine in the course of my diagnosis and treatment.

**Patient or Guardian Signature: X**_____ **Date***/(Fecha)*: _____
*(Firma del Paciente)*

**Print Name** *(Imprimir Nombre)*:_____