

**VITREO RETINAL CONSULTANTS AND SURGEONS, P.A.**

**Phone: 316-683-5611 Fax: 316-683-0294**

**Main Location: 530 N Lorraine Ave Wichita KS 67214**

**Satellite Locations:**

501 Main St      900 Westchester Dr      3120 N Plum St      502 College Dr      300 W Laurel  
Parsons, KS 67357      Salina KS 67401      Hutchinson KS 67502      Garden City KS 67846      Independence 67301

**Full Legal Name:** \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_ **Sex:** \_\_\_ **Marital Status:**  Single  Married  Divorced  Widowed

**Social Security #:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Secondary Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Preferred Method of Contact:**  Call  Text  Email  Patient Portal

**Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino
- Prefer not to answer

**Race (Select all that apply):**

- American Indian or Alaska Native
- Asian
- Black or African American

- Native Hawaiian or Other Pacific Islander

- White
- Other: \_\_\_\_\_
- Prefer not to answer

**Preferred Language:** \_\_\_\_\_

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**EMPLOYMENT INFORMATION**

**Employer Name:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

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**SPOUSE OR GUARANTOR**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_ **Sex:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**EMERGENCY CONTACT**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**NEW PATIENT INSURANCE INTAKE FORM**

**PATIENT INFORMATION**

**Patient Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

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**PRIMARY INSURANCE INFORMATION**

**Insurance Company Name:** \_\_\_\_\_

**Member/Subscriber ID #:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber Date of Birth:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Relationship to Patient:**  Self  Spouse  Parent  Guardian  Other: \_\_\_\_\_

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**SECONDARY INSURANCE (If Applicable)**

**Insurance Company Name:** \_\_\_\_\_

**Member ID #:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber Date of Birth:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Relationship to Patient:**  Self  Spouse  Parent  Guardian  Other: \_\_\_\_\_

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**Patient:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Please circle Yes or No if you have been diagnosed with the following:**

High Cholesterol	yes	no
High Blood Pressure	yes	no
Irregular Heart Beat/Afib	yes	no
Heart Disease	yes	no
History of Heart Attack	yes	no
Asthma/COPD	yes	no
Auto Immune Disease	yes	no
Rheumatoid	yes	no
Sjogren's	yes	no
Lupus	yes	no
Headaches/Migraines	yes	no
Sleep Apnea	yes	no
Stroke	yes	no
Cancer	yes	no
Hepatitis	yes	no
HIV/AIDS	yes	no
Thyroid Disease	yes	no
Diabetes	yes	no
Dementia/Alzheimer's	yes	no
Parkinson's Disease	yes	no

**type:** \_\_\_\_\_

**type:** \_\_\_\_\_

**Eye:**

Retinal Detachment	yes	no
Cataracts	yes	no
Retinal Tear	yes	no
Eye Injury	yes	no

**Patient:**

**DOB:**

**FAMILY HISTORY:**

Please circle any that apply and indicate the family member on the line provided

**Illness:**

**Family Member:**

**DIABETES**

\_\_\_\_\_

**HEART DISEASE**

\_\_\_\_\_

**HYPERTENSION**

\_\_\_\_\_

**CANCER**

\_\_\_\_\_

**STROKE**

\_\_\_\_\_

**BLINDNESS**

\_\_\_\_\_

**GLAUCOMA**

\_\_\_\_\_

**RETINAL DETACHMENT**

\_\_\_\_\_

**MACULAR DEGENERATION**

\_\_\_\_\_

**SOCIAL HISTORY:**

**Tobacco use:**

**Smoker Yes/ No/Former**

**Chewing tobacco Yes/No/Former**

**Alcohol use:**

**Yes/No**

**How much/How Often**



Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

### MEDICATION RECORDS

NAME	STRENGTH	DOSE	HOW OFTEN

### DRUG ALLERGIES & REACTIONS

- NO KNOWN DRUG ALLERGIES
- PENINCILLIN
- SULFA
- CODEINE
- LATEX
- TETRACAINE
- IODINE
- TAPE/ADHESIVE
- OTHER \_\_\_\_\_
- OTHER \_\_\_\_\_

SIGNATURE:

I certify that the information provided on these forms is accurate and complete to the best of my knowledge.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Financial Policy

At Vitreo-Retinal Consultants & Surgeons, we are committed to providing quality care and ensuring transparency in our financial practices. As a courtesy, we will file insurance claims on your behalf; however, patients are ultimately responsible for all charges incurred.

## Do I need a referral or pre-authorization?

If your insurance plan requires a referral authorization from your primary care physician or a pre-authorization from your insurance, you will need to contact your primary care physician or insurance company to be sure it has been obtained. If we have yet to receive authorization prior to your appointment time, we will reschedule. Failure to obtain the referral or preauthorization may result in a lower or no payment from the insurance company, and the balance will become the patient's responsibility.

## Insurance and Balances

It is your responsibility to notify our office promptly of any patient information changes (ie, address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Once your insurance claim has been processed, any remaining balance is your responsibility. If a balance remains unpaid after 90 days, it may be referred to an outside collection agency. To avoid this, please contact our Billing Office to arrange a payment plan before your account is turned over.

**Michael P. Varenhorst, MD Paul D. Weishaar, MD Kumar P. Dalla, MD**  
**Brooke LW Nesmith, MD, JD Thomas A. Woltjer, DO**  
530 N. Lorraine Ave Wichita, KS 67214-4837  
Phone (316) 683-5611 Toll Free (800) 257-3937 Fax (316) 683-029

## Self-Pay Patients

Patients without insurance coverage are kindly asked to pay in full at the time of service. If your appointment is scheduled at least three business days in advance, we will provide a Good Faith Estimate. You may also request one by calling our **Billing Office at 316-683-0222**. Payment plans are available upon request. Emergency services provided to self-pay patients will be billed to the patient.

At the sole discretion of the practice, extended payment arrangements may be made for patients. Please contact our billing office to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

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I have read, understand, and agree with the above Financial Policy. I understand my financial responsibility is to make payments for services provided to me and the courtesy extended by Vitreo-Retinal Consultants and Surgeons to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate Vitreo-Retinal Consultants and Surgeons to extend credit to me for services provided.

**Patient or authorized representative signature:** \_\_\_\_\_

**Patient or authorized representative print name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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# VITREO-RETINAL CONSULTANTS

AND SURGEONS

## Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_  
Please print patient name here

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Do we have your permission to:

Leave a message on your answering machine?

Yes  No

Confirm appointments by leaving messages or speaking with family? Leave pre-medication reminders (if applicable)?

Yes  No

Speak to household members concerning your care?

Yes  No

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice’s Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

Patient or guardian refused to sign

Emergency situation

Other: \_\_\_\_\_