Who referred you to our office _____

Date: _____

Account Number: _____

Jeffrey M. Gosslee M.D., APMC

Retina Specialists

470 Ashley Ridge Blvd. Shreveport, LA 71106

Phone: (318) 841-8844

Patient Registration Form

Please Print

First Name _____ **Middle Initial** _____ **Last Name** _____ **Sex**_____

Mailing Address _____

Street Address (if different from mailing) _____

Employer Name and Address _____

Home Phone _____ **Cell Phone**_____ **Work Phone** _____

Preferred Method of Contact_____ **Date of Birth** _____ **Age**_____

Social Security Number _____ **Marital Status (Please Circle)** Married Single Widowed Divorced Partner

Email address for Patient Portal enrollment, patient education and reminders _____

__ I do not have an email address. __ I have an email address but I decline to participate at this time.

Emergency Contact Name: _____ **Relation** _____ **Phone** _____

Is today's visit related to a work or automobile injury? Yes / No

Medicare Patients: Are you or your spouse covered by an employer group health plan? Yes / No

Disclosures of health information will only be made with your written consent. With whom would you like us to share your health information? _____**No one**

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

IF YOU ARE A DEPENDENT ON AN INSURANCE POLICY, PLEASE PROVIDE THE FOLLOWING FOR THE PRIMARY POLICY HOLDER:

Name: _____ DOB: _____ SS#_____ Relation to patient_____

Is Patient in a Skilled Nursing Facility? Yes or No **Is Patient in a Rehab Facility? Yes or No**

IF YES, PLEASE PROVIDE: FACILITY NAME: _____

ADDRESS: _____ **PHONE #:** _____

I agree that Dr. Jeffrey M. Gosslee, Retina Specialists may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for the purpose of treatment.

Signature: _____ **Date:** _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY PHYSICIAN, Jeffrey M. Gosslee M.D., APMC, OR SUPPLIER FOR SERVICE DESCRIBED. I AGREE IF AN INSURANCE CHECK IS MAILED TO ME, I WILL IMMEDIATELY FORWARD TO RETINA SPECIALISTS TO BE POSTED. I understand that I am financially responsible for all charges incurred. We will file your claim to the insurance on file. Dr. Gosslee is contracted with your insurance plan to collect a co-pay, deductible or co-insurance at the time of service.

_____

SIGNED (INSURED OR AUTHORIZED PERSON)

Primary Pharmacy:

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

Secondary Pharmacy: (IF APPLICABLE)

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE #: _____

FAX#: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY (circle all that apply)

Blurred Vision, Blind Spots, Diabetic Eye Exam, Distorted Vision, Eye Pain, Flashes of Light, Floaters, Vision Loss, Trauma, Other: _____

Drug Allergies and Reactions: _____

CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

Name: _____ DOB: _____ Date: _____

DRUG NAME (PLEASE PRINT)	DOSAGE	Route (Oral, Nasal, IM, Topical, Suppository)

Medical History

(List all medical problems such as Diabetes, Hypertension, Epilepsy, etc)

_____

_____

_____

_____

Surgical history including Eye

Please list all **general surgeries** (**including eye**) and/or procedures and hospitalizations and the approximate date.

Surgery/Procedure/hospitalization	Date

Family History

Is there a family history of	Yes	No		
Cataracts			Relative	
Cancer			Relative	
Glaucoma			Relative	
Mental			Relative	
Hypertension			Relative	
Retinal Disease			Relative	
Retinal Detachment			Relative	
Heart Disease			Relative	
Stroke			Relative	

Medical History / Review of Systems

Name:_____ DOB:_____ Today's Date: _____

Do you smoke? **Yes or No** If so, how many packs a day_____ How Long_____ Do you drink alcohol? **Yes or No** If so, how often? _____

Have you had any recent falls? **Yes or No** If yes, Did you obtain any injuries? **Yes or No** Do you exercise regularly? **Yes or No** Type of exercise_____

Personal medical history		**Insulin Dependent**		**Type 1**	**Type 2**	**Year Diagnosed**	**Blood Sugar**	**Last A1C**
Constitutional:	**Check if YES**	YES	NO					
Shortness of Breath		**Urinary:**		**Check if Yes**	**Neurologic:**		**Check if Yes**	
Palpitations		Frequency			Weakness			
Edema		Incontinent			Headaches			
Weakness/Lack of energy		Hematuria			Seizures			
Confusion		Dysuria			Trouble with balance			
Dizziness		Urgency			Numbness			
Fever		Erectile Dysfunction			Loss of Memory			
Chills		**Musculoskeletal:**			Stroke(s)			
Insomnia		Joint pain			Tremors			
HEENT:		Arthritis			**Endocrinology:**			
Blurred vision		Back pain			Hypothyroidism			
Double vision		Muscle aches			Hyperthyroidism			
Glaucoma		Tenderness			Excess thirst			
Cataracts		Gout			Diabetes			
Hearing difficulty		**Dermatology:**			Kidney failure			
Decrease in vision		Rash			**Hematology:**			
Macular Degeneration		Itching			Bleeding			
Respiratory:		Eczema			Anemia			
Wheezing/Asthma		Psoriasis			Clotting problems			
Shortness of Breath		Shingles			Easily bruising			
COPD		Skin cancer			**Cardiovascular:**			
Cough		**Urinary:**			Chest pain			
Sinuses/Seasonal Allergies		Frequency			Palpitations			
Digestive System:		Burning			Low blood pressure			
Abdominal pain		Hesitancy			High blood pressure			
Indigestion		Infections			High cholesterol			
Acid reflux Nausea		Blood in urine			**Psychiatric:**			
Ulcers		Erectile dysfunction			Depression			
Gallstones		Amputation			Anxiety			
Constipation					Dementia			

I have been provided the opportunity to read **Jeffrey M. Gosslee, MD** Notice of Privacy Policy. I give my permission to use my personal health information where you have authorized us to do so. This signature page will remain in the patient's chart as record of acceptance and the Notice of Privacy Policy is for the patient (or patient's representative) to keep for his/her records.

*You may receive a copy of our Notice of Privacy upon request at check-in.

☐

- By checking the box above, I have declined to accept the Notice of Privacy.

Patient's Name (PRINT): _____

Signature (Patient or Authorized Representative): _____

Relationship to Patient if other than Self: _____

Address: _____

Telephone Number: _____

Date: _____

PLEASE INFORM DR. GOSSLEE AND STAFF OF ALL THE PHYSICIANS YOU ARE CURRENTLY SEEING

SPECIALTY	PHYSICIAN NAME	ADDRESS	PHONE NUMBER

1. **Ophthalmologist / Optometrist:** _____
2. **Cardiologist:** _____
3. **Internist/PCP:** _____
4. **Podiatrist:** _____
5. **Endocrinologist:** _____
6. **Nephrologist:** _____
7. **Vascular Consultant:** _____
8. **Urologist:** _____
9. **Other:** _____

Dr. Jeffrey M. Gosslee, M.D., A.P.M.C.

470 Ashley Ridge Blvd

Shreveport, LA 71106

(318) 841-8844

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you should carefully consider making arrangements not to drive yourself. Some patients may experience the effects of dilation from 6 to 72 hours. For others, the effects may wear off sooner.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Jeffrey M. Gosslee, and/or one of his assistants to administer dilating eye drops. The eye drops are necessary to evaluate my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

IMPORTANT INFORMATION REGARDING INSURANCE COVERAGE FOR LAB TESTING

Throughout your treatment, Dr. Gosslee may periodically order lab tests. Some tests will be ordered from Quest or Lab Corp, but we often send our labs to Clinical Pathology 470 Ashley Ridge Blvd. Shreveport, LA 71106.

If your insurer has designated another lab besides Clinical Pathology, please let us know so that in the case labs are ordered, we can provide you with an order to take to the lab designated by your insurance plan. Failure to use the lab company specified by your insurance could result in hundreds of dollars of out of pocket expense to the patient. The lab company will bill you for any balance left unpaid by your insurance plan.

Patient/Guardian Signature	Date
Witness	Date

Financial Policy for Jeffrey Gosslee MD APMC

1. All patients must provide accurate and complete personal and insurance information prior to being seen by the physician, physician assistant, nurse practitioner or other medical care provider/practitioner.
2. Payment is required at the time of service. Retina Specialists accepts payment by cash, check and credit/debit card. There will be a $35 fee for all returned checks.
3. Retina Specialists will gladly file a claim with your insurance company; however, it is your responsibility to comply with all pre-determination, pre-authorization and/ or notification requirements as may be required by your insurance plan. While many of the services provided by Retina Specialists may be covered benefits of your insurance plan, how these benefits are paid by your insurance provider and/or whether or not certain services are considered to be non-covered services is determined strictly by your insurance provider and not by Retina Specialists. It is your personal responsibility to understand the limitations and exclusions of your insurance plan, as well as to understand your co-pays, deductibles, in-network and out of network coverage including any and all applicable limitations, inclusions and/or exclusions.
4. Retina Specialists requires that the guarantor agree to be personally liable for all balances due or that may become due related to today's visit.
5. The fees for Retina Specialists services are reasonable and customary fees for this region and specialty. If the Patient's insurance company reimburses at a different rate than what is billed by Retina Specialists, the Patient may be responsible for any balance remaining.
6. We understand situations arise that can cause you to miss your scheduled appointment. However, we will charge a $25 no show fee for the second missed appointment. Please call at least 24 hours prior to your appointment if you need to cancel or reschedule so that we can schedule another patient in that appointment slot.
7. Should it be necessary to forward an account balance to a collection agency, the guarantor agrees to assume financial responsibility for reasonable collection costs.
8. The Patient's personal information will be updated at least one time per year to verify the information on file is accurate. It is the responsibility of the patient to notify Retina Specialists of any changes of the personal and/or insurance information provided on this form.
9. Federal laws require that Retina Specialists submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. It is insurance fraud to change this information in order to try to obtain payment on a claim from an insurance company.

I agree that in the event my insurance provider does not pay for some/all of the charges associated with and incurred for today's visit, I will pay any remaining balance due and that balance will be my personal financial responsibility. I understand that this Medical Treatment and Financial Agreement is and will be valid for any and all services provided by Retina Specialists effective from the date this Medical Treatment and Financial Agreement is signed by me and does not expire unless and until I inform Retina Specialists directly that I no longer wish to have this Medical Treatment and Financial Agreement in effect.

Signature of Patient/Patient Representative:_____ **Date:**_____

Relationship to Patient:_____ **Witness:**_____