MICHAEL J. GROTH, M.D.
Ophthalmic Plastic and Reconstructive Surgery

PATIENT REGISTRATION SHEET

PATIENT'S LEGAL NAME: _____DATE:_____

PATIENT'S PREFERRED NAME (If different from legal name):_____

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: ( )_____ **(WILL BE USED FOR APPOINTMENT REMINDERS)**

Home Phone: ( )_____ May leave a message on your home phone? ☐Yes ☐ No

EMAIL: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other:_____

Referred By: _____ Driver's License: _____

Your Occupation: _____ Employer's Name: _____

Work Address: _____ Work Phone: ( )_____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone: _____

Preferred Pharmacy: _____

Reason For Today's Consultation: _____

INSURANCE INFORMATION

Primary Carrier: _____ Group#:_____ Policy #:_____
Name of Insured: _____ Insured's Date of Birth: _____
Insured's Employer: _____ Employer's Phone: _____
Employer's Address: _____
Send Claims to (Address/Phone):_____

Secondary Carrier:_____ Group#:_____ Policy #:_____
Name of Insured: _____ Insured's Date of Birth: _____
Insured's Employer: _____ Employer's Phone: _____
Employer's Address: _____
Send Claims to (Address/Phone):_____
_____

****YOUR CARRIER REQUIRES THE LISTING OF INSURED'S EMPLOYMENT INFO AND DATE OF BIRTH****

PLEASE CHECK HOW YOU WILL PAY FOR TODAY'S SERVICES (Due at time services are rendered):
☐ Check ☐ Cash ☐Visa/Mastercard/AMEX

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PATIENT MEDICAL MISTORY

PATIENT NAME: _____ DOB: _____

HEIGHT: _____WEIGHT: _____ Date of Last Complete Physical Examination: _____

Primary Care Physician: _____ Physician's Telephone: ( )_____

☐ **NO KNOWN ALLERGIES** ☐ **ALLERGIES** (to medications, foods, etc.): _____
_____

***ALLERGIC TO: ☐ EGGS ☐SOYBEAN ☐ LATEX ☐ NONE**
* If Yes, Please Explain Reaction:_____

MEDICATIONS (taken regularly or occasionally, prescription and non-prescription): _____
_____

***ARE YOU CURRENTLY TAKING ANY FORM OF SEMAGLUTIDE? ☐ NO ☐YES, _____**

Have You Taken Cortisone or Steroid Medication the Past 6 Months? ☐ **NO** ☐**YES, _____**

Do You Have Any Current or Recent Medical Problems? If so, are you under a doctor's care for these? Please Explain:_____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? (Please check all that apply):

- ☐ **Contact Lenses**
- ☐ **Glaucoma**
- ☐ **Diabetes**
- ☐ **Heart/Circulation problems**
- ☐ **Mitral Valve Prolapse**
- ☐ **Pacemaker**
- ☐ **Lung/Respiratory problems**
- ☐ **Asthma**
- ☐ **Dizziness/Fainting**
- ☐ **Blood or Bleeding Skin Problems**
- ☐ **High Blood Pressure**
- ☐ **Implants (including hardware)**
- ☐ **Cataract(s)**
- ☐ **Anemia**
- ☐ **Kidney/Urinary Problems**
- ☐ **Cancer**
- ☐ **Seizure or Epilepsy**
- ☐ **Stroke**
- ☐ **Hiatal Hernia**
- ☐ **AIDS/HIV Positive**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Other (please list):_____**
- ☐ **NONE OF THE ABOVE**

HAVE YOU EVER HAD AN ABNORMAL: ☐ EKG ☐ CHEST X-RAY ☐BLOOD OR LAB TEST

DATES AND TYPES OF PREVIOUS SURGERIES: _____
_____

HAVE YOU OR A BLOOD RELATION EVER HAD ANY COMPLICATIONS OR PROBLEMS WITH SURGERY OR ANESTHESIA? IF YES, PLEASE EXPLAIN: _____
_____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANYTHING OTHER THAN SURGERY? IF YES, PLEASE EXPLAIN: _____

Do You Drink Alcohol? ☐**YES**, How Much? _____☐ **NO** Do You Smoke? ☐**YES**, How Much? _____☐ **NO**

ARE YOU PREGNANT? ☐**YES** ☐ **NO** ARE YOU NURSING? ☐**YES** ☐ **NO**

PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

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FINANCIAL AGREEMENT AND AUTHORIZATION OF BENEFITS

PATIENT'S NAME_____

RESPONSIBLE PARTY_____**RELATION:**_____

1. **Michael J. Groth, M.D., the surgical facility, and the anesthesiologist, are NOT contracted providers for any insurance companies. Payment is always required at the time services are rendered or by the date specified in the financial agreement, whichever comes first. Insurance claims can ONLY be submitted for medically necessary procedures upon request as a courtesy. I do hereby agree that I am ultimately responsible for paying for all services rendered to me by Michael J. Groth, M.D. I have read the above office policy and understand it.**

_____ _____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

2. Provided that my insurance can be billed for these services, I agree to accept **only** the amount my insurance carrier reimburses, no more and no less. A copy of this authorization is as valid as the original, and this authorization will remain in effect until I rescind it in writing.

_____ _____
SIGNATURE OF INSURED/AUTHORIZED PERSON DATE

3. I authorize the release of any medical or other information necessary to process claims to my insurance company. A copy of this authorization is as valid as the original, and this authorization will remain in effect until rescinded by me in writing.

_____ _____
SIGNATURE OF INSURED/AUTHORIZED PERSON DATE

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YOU ONLY HAVE TO COMPLETE THIS FORM IF YOU HAVE MEDICARE

PRIVATE CONTRACT FOR MEDICARE BENEFICIARY

Dr. Michael Groth has opted out of Medicare. The Medicare Administration requires that all Medicare patients read, understand and sign the following:

I am aware that the office requires payment at the time services are provided. I do hereby agree that I am ultimately responsible for paying for all services rendered to me by Michael J. Groth, M.D.

_____
Initials

I agree that I cannot submit a claim or request Michael J. Groth, M.D. to submit a claim for payment under Medicare, even if such items and services are otherwise covered by Medicare.

_____
Initials

I acknowledge that Medigap plans do not, and other supplemental insurance plans may choose not to, make payment for items and services rendered by Michael J. Groth, M.D.

_____
Initials

I acknowledge that Michael J. Groth, M.D. is not limited in the amount that he may charge for the items and services rendered. I understand that no reimbursement will be provided by Medicare to Michael J. Groth, M.D. for services rendered.

_____
Initials

I understand that a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to me under this contract.

_____
Initials

I, _____, hereby understand that Michael J. Groth, M.D. is not a provider for Medicare and that I am ultimately responsible for items and services rendered. I have read the above office policy and understand it.

_____ _____
Signature Date

MICHAEL J. GROTH, M.D.
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below.

_____	_____	_____
Date	Initials	Reason

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PATIENT AUTHORIZATION FORM

I hereby authorize any or all of the designated parties listed below to request and receive the release of any protected health information related to my treatment, payment or administrative operations. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

This authorization shall remain in effect from the date signed below until revoked.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your practice at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case, you may refuse to provide that research-related treatment).

Patient Name:_____

Signature:_____ Date:_____

Relationship to patient, if minor:_____

Privacy Officer:_____