



PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION:

Last Name:				First:		Middle:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female							
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower				<input type="checkbox"/> Other			
Spouse's Name (if applicable):							
Patient's Date of Birth:							
Preferred Language:							
Address:		City:		State:		Zip:	
Social Security Number:							
Email address:							
Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text							
Home Phone:		Cell Phone:					
Ethnicity: <input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American			
<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Caucasian/White			
Work: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Doesn't work							
School: <input type="checkbox"/> Elementary Student <input type="checkbox"/> High School Student <input type="checkbox"/> College Student							
Living Situation: <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives in facility							
Occupation:		Employer:					
Employer Address:		Employer Phone:					
Emergency Contact:		Emergency Phone:					
Preferred Pharmacy:		Pharmacy Location:					

PERSON RESPONSIBLE FOR ACCOUNT (if other than self):

Name:		Relationship:		Date of Birth:	
SSN:		Employer:			

INSURANCE INFORMATION:

Primary Medical Insurance:			
Policy Number:		Group Number:	
Policy Holder:		Relationship:	
DOB:	SSN:	Employer:	
Secondary Medical Insurance:			
Policy Number:		Group Number:	
Do you have one of these vision plans? <input type="checkbox"/> VSP <input type="checkbox"/> Spectera <input type="checkbox"/> Eyemed <input type="checkbox"/> Physicians Eyecare			

FAMILY DOCTOR:			
REFERRING DOCTOR (if applicable):			

By signing this document, I confirm my information to be correct.

Signature:		Date:	
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Southern Eye Associates

FINANCIAL POLICY

Thank you for choosing Southern Eye Associates of SC, PA as your health care provider. Please understand that payment for provided services is due at the time services are rendered. We accept cash, checks and all major credit cards. Any additional testing, **including refractions, are an additional charge.**

If You Have Insurance

When we are a Participating Provider, all applicable Co-payments, Deductibles, Lens Fitting and Refraction charges, which are not covered by your insurance company, are **due at the time the service is provided.** **Refraction** tests are \$40.00 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct your vision. **Medicare** and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing, will be the responsibility of the patient and are due at the time of the service.

We will bill your insurance company; however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all, of the services provided may be non-covered under the Medicare program. **When we are NOT a Participating Provider**, the patient is fully responsible for all charges.

Collection Fees

All returned checks, regardless of reason, will be assessed a \$25.00 fee and any additional collection expenses incurred to recover the original amount due for the medical services rendered.

By signing below, I agree to pay all amounts owed when due. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount (s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.)

The terms of this paragraph shall apply to all amount (s) incurred by me or by any individual for whom I have legal responsibility whether such amount (s) are incurred today or after today. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Southern Eye Associates of SC, PA or anyone acting on its behalf. I understand and agree that such calls may be initiated by Southern Eye Associates of SC, PA or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agency (ies), and the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages- some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me acting on my behalf.

Acknowledgement of Privacy Practice

We are required to notify you of our privacy practices, and have you sign that you have reviewed this information. Southern Eye Associates of SC, PA maintain a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices may be found in our written publication.

I have been given a copy of the Southern Eye Associates of SC, PA Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Southern Eye Associates of SC, PA has the right to change this notice at any time.

I would like to authorize my medical information to be disclosed/released with the following person (s):

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

This authorization permits Southern Eye Associates to release your protected health information to the above person or persons without any further authorization from you. YOU may revoke this authorization in writing and send to Southern Eye Associates, 113 Doctors Drive, Greenville, SC 29605.

My signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature _____ Date: _____
Signature of Patient or Responsible Party