CAROLINA EYE CENTER
PATIENT INFORMATION

Chart # ____________ Today's Date ____________

In order to serve you properly we will need the following information (please print):

Mr. Mrs. Ms.	Patient Name: Last First M.I.	Sex M F	Date of Birth	Age

Patient Social Security #:	Marital Status: Single ___ Married ___ Widowed ___ Divorced ___

Parent or Guardian Name (if child):	Date of Birth	Relationship:

Residence Address: City State Zip	Home Phone:

SC Driver's License Number (for payment verification): ____________	Cell Phone:	Work Phone:

Name of Employer: ☐ Full Time ☐ Part Time ☐ Retired	Employer Address:

Spouses' Name:	Spouse's Date of Birth:	Spouse's Soc. Sec. #:	Home Phone:

Emergency contact (relative/friend NOT residing with you): Name ____________ Phone ____________	Family Physician : Name ____________ Phone ____________

Referred by: Doctor Referral ______ Doctor's Name ____________ Insurance Company ____________
Family Member _____ Friend _____ Yellow Pages _____ Newspaper _____ Radio _____ Website _____

PRIMARY Major Medical Insurance Company Name ____________
Address ____________ Phone ____________

Insured's Name:	Policy No:	Date of Birth:	Relationship to Patient:

Insured's Employer: ☐ Full Time ☐ Part Time ☐ Retired	Employer Address:	Work Phone:

SECONDARY Major Medical Insurance Company Name ____________
Address ____________ Phone ____________

Insured's Name:	Policy No:	Date of Birth:	Relationship to Patient:

ROUTINE Eye Care Insurance: VSP ______ VCP ______ EYE MED ______ VISION ONE ______ Other ______

Insured's Name:	Identification Number:	Date of Birth:	Relationship to Patient:

LIFETIME AUTHORIZATION

I authorize reports of my evaluation, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that I have or will identify to you.
I authorize any holder of medical or other information about me, to release to the Social Security Administration and The Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if this is a Workmen's Compensation claim, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all costs of collection agency fees, attorney fees and court costs, if any.

SIGNATURE: ____________________ DATE: ____________

I acknowledge that the Carolina Eye Center has given me a copy of the Notice of Privacy Practices.

SIGNATURE: ____________________ DATE: ____________

CAROLINA EYE CENTER

Individual and Family Past & Current Complete Health History

NAME:
AGE
SEX: M F
REFERRED BY:
OCCUPATION:

TODAY'S DATE:
BIRTH DATE:
MARITAL STATUS:
HOBBIES/INTERESTS:

DO YOU HAVE:

YES NO CATARACTS
YES NO GLAUCOMA
YES NO DIABETES
YES NO MACULAR DEGENERATION
YES NO GLASSES
YES NO CONTACT LENSES
YES NO POOR EYESIGHT
YES NO DIFFICULTY SEEING T.V.
YES NO DIFFICULTY DRIVING
YES NO DIFFICULTY DRIVING AT NIGHT
YES NO A HISTORY OF FALLING
YES NO EYE PAIN
YES NO FREQUENT HEADACHES
YES NO BAGGY EYELIDS
YES NO GROWTHS ON EYES OR FACE
YES NO A HISTORY OF SKIN CANCER
YES NO HIGH BLOOD PRESSURE
YES NO HEART DISEASE
YES NO LUNG DISEASE
YES NO THYROID DISEASE
YES NO POOR HEARING
YES NO ARTHRITIS
YES NO CURRENT SMOKER? PACKS PER DAY ______
YES NO ANXIETY, DEPRESSION

DO ANY OF YOUR BLOOD RELATIVES HAVE/HAD:

YES NO GLAUCOMA
YES NO MACULAR DEGENERATION
YES NO CATARACTS
YES NO MIGRAINES
YES NO DIABETES

LIST OTHER PAST AND CURRENT SERIOUS DISEASES OR HOSPITALIZATIONS:

LIST CURRENT MEDICATIONS:

LIST ALLERGIES TO MEDICATIONS:

PREFERRED PHARMACY: ______________________

PHONE: ______________________

OFFICE USE ONLY

DATES COMPLETELY REVIEWED AND UPDATED:

CAROLINA EYE CENTER, P.A.

3227-C Sunset Blvd.
West Columbia, SC 29169
803-794-0000

FINANCIAL POLICY

Communication is important to you as a patient and to us as Healthcare Providers. If you have any questions regarding your fees, please do not hesitate to contact the business office. We are happy to serve you.

Standard charges have been established for all services provided by Carolina Eye Center, P.A. **A $10.00 service charge will be charged to your account if your payment or co-payment is not collected at the time of service.**

HMO/POS Insurance: You must have a current HMO card, and a referral sheet from your Primary Care Physician, and pay your applicable co-pay or deductible. If you do not have your referral, your visit may be rescheduled or you may be financially responsible for the entire amount. Your applicable co-pay or deductible is due at the time of service.

PPO Insurance: You must have a current PPO card. Your applicable co-pay or deductible is due at the time of service.

Medicare Insurance: You must have a current Medicare card, and be prepared to pay your deductible and/or 20% of the allowed charges, if you do not carry a secondary medical insurance.

Private Insurance: We expect you to pay your deductible and/or 20% at the time the services are rendered. We will file a claim with your insurance carrier.

No Insurance/Self Pay: We ask for payment in full at the time of service. If you have a surgical procedure, you will be billed on a separate bill after pathology is received back in our office.

Current Insurance: **If the insurance information you give us at the time of your visit is not correct, you will be held responsible for payment.**

If we do not receive all of your information (i.e. SSN, Insurance Card) within 10 days after you are seen in our office, you will be responsible for paying the entire charges and filing your own insurance.

For your convenience, we accept payment by Cash, Personal Check, MasterCard, Visa, American Express, Discover Charge Card, and Debit Card with Visa/Master Card logs. There will be a $30.00 charge on all returned checks.

PLEASE REMEMBER THAT REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR YOUR BILL. IF YOUR INSURANCE CARRIER HAS NOT PAID YOUR CLAIM IN FULL WITHIN 60 DAYS, YOU WILL BE CONTACTED REGARDING PAYMENT.

All outstanding balances must be paid in full within 90 days of the date of service unless a financial agreement has been made. If a financial agreement is necessary, you must contact our Billing Department.

*Should it become necessary for us to consult a collection agency concerning your account, you (the patient) will be responsible for all charges and fees incurred by Carolina Eye Center during collection procedures which is 50% of the amount past due plus court cost.

______________________________ **Patient Signature**

______________________________ **Date**

01/23/08
Front Desk
MRW

Carolina Eye Center

3227-C Sunset Blvd.
West Columbia, SC 29169
803-794-0000

1. **What is a refraction?**
   Refraction is a process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

2. **Why is it sometimes necessary?**
   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. **For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to justify to insurance companies the medical necessity for cataract surgery.** We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, a refraction is an essential part of an eye exam; however, **Medicare and most insurance companies DO NOT cover the charge for a refraction.**

   ***It is important to understand that if you decline, we may not be able to determine the cause for your decrease in vision.**

3. **How much is the procedure?**
   Our office policy is to charge $30.00 for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. **Again, typically most insurance companies, including Medicare, do not reimburse for refractions.** However, we will bill your insurance company according to the individual contracted fee schedules. If your insurance pays the fee, we will gladly refund you this **prepaid** $30.00 amount once we receive payment from your insurance.

Note: This fee is due and payable **whether or not** you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor's and technician's time and effort in achieving this process.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay and deductible are separate from, and not included in, the refraction fee.

______________________________ ________________________
Signature Date

Carolina Eye Center

Contact Lens Policy and Fitting/Management and Evaluation Fees

Contact lenses are medical devices, regulated by the FDA. This means that the doctor has to evaluate the health of your eyes and the fit of your contacts every year in order to determine the optimum prescription for you eyes. Contact lens examinations are required on a yearly basis. These tests are done to make sure your eyes are healthy, that the lenses fit your eyes properly, and to ensure that you are seeing as clearly as possible. **All contact lens patients will be charged a contact lens fitting/management and evaluation fee.** The fee varies based upon the type of contact lens and whether you are a New Patient or an Established Patient. In most cases, insurance companies consider contact lenses "not necessary" and they will not cover these charges. The services received for the fee include the fitting/management and evaluation of contact lenses, evaluating your corneal health and assessing corneal measurements, any follow-up visits needed for new contact lens wearers, and a contact lens starter kit as well as training of care and use of lenses by the optician is included.

Contact Lens Evaluation: The contact lens evaluation is not part of the standard eye exam. There is an additional fee for a contact lens evaluation/fitting. These fees are to be paid on the date of service.

The following fees apply:

New Patient Toric-$75
Established Patient Toric-$45
New Patient Regular-$60
Established Patient Regular-$35

By signing below, I have read the above and agree to these terms.

_______________________________ _______________________
Signature of Patient/Guardian Date

Front Desk
07/10/08
MRW

CAROLINA EYE CENTER
3227-C Sunset Boulevard
West Columbia, SC 29169
803-794-0000
www.carolinaeyecenters.com
www.facebook.com/carolinaeyecenter

Name: (please print)______________________________ Date: ________________

E-mail: (please print)____

Yes! I would like for you to email me information about the following: (please check all that apply)

Eye Conditions:

_____Cataracts
_____Macular Degeneration
_____Glaucoma
_____Diabetic Retinopathy
_____Allergies
_____Dry Eye
_____Conjunctivitis (Pink Eye)
_____Blepharitis
_____Retinal Detachment
_____Pinguecula
_____Strabismus (Lazy Eye)
_____Stye
_____Vitreous Detachment
_____Vitreous Floaters
_____Astigmatism
_____Hyperopia (Farsightedness)
_____Myopia (Nearsightedness)
_____Presbyopia

_____Blepharoplasty
_____Cataract Surgery
_____Diabetic Retinopathy
_____Glaucoma Laser Treatments
_____LASIK Surgery
_____Muscle Relaxing Injections
_____Refractive Lens Exchange

Lenses & Frames:

_____Anti-Reflective Treatment
_____Computer Lens Overview
_____Frames Selection Overview
_____High-Index Lenses
_____Polarized Lenses
_____Polycarbonate Lenses
_____Progressive Lenses
_____Sunglasses Overview
_____Variable Tinted Lenses

Contact Lenses:

_____Contact Lens Compliance
_____Contact Lens Care, Insertion/Removal
_____Monovision Overview

Patient Signature: ____