RETINA OF COASTAL CAROLINA

PATIENT REGISTRATION FORM

PATIENT INFORMATION

	Pt Email:	
Last Name:	First Name:	Middle:
Mailing Address:		County:
Street Address:		
City:	State:	Zip:
Home phone:( )	Work phone:( )	Cell phone:( )

Preferred method of contact (Circle One): Home Phone / Cell Phone / Mail (USPS) / Secure Email / Text (SMS) / Patient Portal / No Preference / No Reminders

Pref Language:	Race (Circle One):	American Indian or Alaska Native/ Asian / African American / Native Hawaiian or Other Pacific Islander / White / Other
Hispanic or Latino: Yes / No		

Date of Birth: / /	Age	Sex: ( )Male ( )Female	Social Security Number:

Marital Status: ( )Married ( )Single ( )Widowed ( )Separated ( )Divorced

Occupation:	Employer:
Address:	

Spouse's name:	Social Security #:	Date of Birth: / /

EMERGENCY CONTACT

Last Name:	First Name:	Middle:
Mailing Address:		Home phone:( )

RESPONSIBLE PARTY (Parent, Guardian or Power or Attorney)

Name:	Relationship:
Street Address:	
Mailing Address:	

City:	State:	Zip:	
Home phone:( )	Work phone:( )	Date of Birth: / /	Age
Sex: ( )Male ( )Female	Social Security Number:		

DOCTOR INFORMATION

Eye Doctor's Name:	City:	phone:( )
Medical Doctor's Name:	City:	phone:( )
Pharmacy's Name:	City:	phone: ( )

REFERRAL INFORMATION

I was referred by: ( )Doctor ______________________________ ( )Friend/Patient ( )Newspaper ( )Radio

( )Television ( )Yellow pages ( )Internet ( )Other (specify):

Why were you referred?

Today's Date: _______________________ Update: ____________________

RETINA OF COASTAL CAROLINA
INSURANCE INFORMATION

PRIMARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

SECONDARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

TERTIARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

HOW WILL YOU PAY FOR ANY COPAYMENT, DEDUCTIBLE OR CO-INSURANCE?

( )CASH ( )CHECK ( )CREDIT CARD

ASSIGNMENT AND RELEASE

I give my permission for Retina of Coastal Carolina to; 1) release to the Social Security Administration or other insurance carriers, information concerning my insurance claim, 2) file my insurance claim with Medicare or an insurance company and assign the benefits paid to Retina of Coastal Carolina, 3) contact any medical professional whom my doctor deems necessary for the furtherance of my medical care, 4) to leave a message reminding me of a medical/surgical appointment on any answering machine at my telephone home number, and 5) to leave a message reminding me of a medical/surgical appointment with any person answering my telephone.

I understand that; 1) my consent is good for all services for the remainder of my life, and 2) I am responsible for any unpaid balance not paid by my insurance company.

I certify that the information I have given is correct and that I have complete authority to execute this document on behalf of myself or the patient.

( ) I do not wish to have messages about my medical/surgical appointments left on my answering machine or with anyone other than me.

SIGNATURE OF ______________________________________ DATE:____________________
RESPONSIBLE PARTY:

RETINA OF COASTAL CAROLINA
FINANCIAL POLICY

Thank you for choosing ROCC for your healthcare needs. Please understand that payment of your bill is considered your responsibility. The following is a statement of our Financial Policy which we require you to read and to sign prior to any treatment. To achieve the practice goals of providing the finest medical care at the lowest possible cost and meet our financial obligations, we need your assistance in the following:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AMERICAN EXPRESS, AND MASTERCARD.

In regards to insurance plans, if we are participating providers, all co-pays and deductibles are due at check-in for your scheduled appointment unless other arrangements were made. Payment is due a minimum of one (1) week prior to any scheduled surgery.

If you have insurance coverage, we will file the claim for you. Payment for treatment remains your responsibility**. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO OBTAIN AND PROVIDE THIS.**

If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. Please be aware that some of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. We will inform you in advance of such charges.

We will check the status of your insurance benefits when we schedule any procedure. If your deductible has not been met, we will require payment of that amount and any additional co-insurance or co-pay responsibility. Payments are applied to your account promptly and any credit balance will be refunded to you within 30 days.

If you do not have insurance coverage, a patient financial counselor is available to provide you with an estimate of charges for your visit. **THIS IS AN ESTIMATE ONLY** and may vary depending on tests or treatments determined needed upon examination by the doctor.

Return checks may be subject to any bank fees and a collection fee of $25.00 per check.

The parent and/or adult accompanying a minor is responsible for full payment at time of service.

If you have any questions about financial arrangements, please feel free to talk with our Patient Financial Counselor at 910-254-2023 Ext.316. We will make every effort to clarify any concerns regarding your financial responsibility.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS.

______________________________ ______________________________

Signature of Patient or Responsible Party Date

______________________________ ______________________________

Print Patient Name Date of Birth