# RETINA OF COASTAL CAROLINA

## PATIENT REGISTRATION FORM

LAST NAME_____FIRST NAME_____MIDDLE_____

MAILING ADDRESS _____

STREET ADDRESS _____

CITY _____ STATE _____ZIP CODE _____

HOME # _____ CELL #:_____ EMAIL_____

PREFERRED METHOD OF CONTACT: HOME/CELL PHONE / MAIL / PATIENT PORTAL / NO PREFERENCE

DATE OF BIRTH_____ SOCIAL SECURITY # _____ SEX (M/F) ____ MARITAL STATUS_____

SPOUSE'S NAME_____ DATE OF BIRTH_____

PREFERRED LANGUAGE _____ RACE_____ HISPANIC OR LATINO: YES / NO

RETINA OF COASTAL CAROLINA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

LANGUAGE ASSISTANCE AVAILABLE: Español (Spanish) | 繁體中文 (Chinese) | Tiếng Việt (Vietnamese) | 한국어 (Korean) | Tagalog | Русский (Russian) | العربية (Arabic) | Kreyòl Ayisyen (Haitian Creole) | Français (French) | Polski (Polish) | Português (Portuguese) | Italiano (Italian) | Deutsch (German) | 日本語 (Japanese) | فارسی (Farsi)

## RESPONSIBLE PARTY (other than self)

NAME_____ DOB_____ RELATIONSHIP_____

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE#_____

## EMPLOYER INFORMATION

COMPANY NAME _____ WORK PHONE_____

## EMERGENCY CONTACT

NAME_____ PHONE_____

## DOCTOR INFORMATION

EYE DOCTOR_____ CITY_____ PHONE_____

PRIMARY CARE DOCTOR_____ CITY_____ PHONE_____

REFERRED BY: DOCTOR / FRIEND/PATIENT / NEWSPAPER / INTERNET / OTHER_____

PHARMACY INFORMATION_____

# RETINA OF COASTAL CAROLINA

## INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID#_____

SECONDARY INSURANCE_____ ID#_____

TERTIARY INSURANCE_____ ID#_____

**HOW WILL YOU PAY FOR ANY COPAYS, DEDUCTIBLES COINSURANCE OR NON COVERED SERVICES?**

( ) 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 carrier, 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, and 4) to leave a message to remind me of a medical/surgical appointment on any answering machine at my phone number or with any person answering my phone unless otherwise noted below.

**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 RESPONSIBLE PARTY_____ DATE_____

# 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 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 assistance in the following.

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

In regards to insurance plans, all copays, deductibles, and coinsurances are due at time of service 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 RESPONSBILITY 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 Medicare 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 coinsurance or copay responsibility. Payments are applied to your account promptly and any credit balance after insurance has paid will be refunded to you within 30 days. Please note that these are estimates only and are subject to change when your claim is reviewed and submitted to your insurance company.

**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 deemed necessary 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 any of our Patient Financial Counselors at 910-254-2023 ext 126. 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 RESPONSIBLE PARTY_____ DATE_____

PRINT NAME _____ DATE OF BIRTH_____

# RETINA OF COASTAL CAROLINA

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION / IDENTITY THEFT PREVENTION**

**Information to be Used or Disclosed in this authorization includes:**

( ) Clinical ( ) Billing/Insurance ( ) Pharmacy ( ) Appointment ( ) Demographic Info

**Persons to Whom Information May Be Disclosed:**

| Name of person | DOB | Relationship |
|---|---|---|
| Name of person | DOB | Relationship |
| Name of person | DOB | Relationship |

**Expiration Date of Authorization**
This authorization is effective through treatment unless revoked or terminated by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**
You may revoke or terminate this authorization by submitting a written revocation to Retina of Coastal Carolina. You should contact the Office Administrator to terminate this authorization.

**Potential for Re-disclosure**
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Signature**

Name of patient

Signature of Patient Date

Signature of Patient Representative Relationship of Patient Representative to Patient