Date: _____ Do you go by another name? _____

SS#: _____ Last Name _____ First Name _____ MI ___

Address: _____ Apt# _____ City _____ State _____ Zip _____

Cell (_____) _____-_____ Other (_____) _____-_____ Email: _____

Birth Date: _____/_____/_____ Gender: Male / Female Marital Status: Married / Single / Other

Primary Care Doctor? _____ Phone Number: _____

INSURANCE INFORMATION

Policy Holder: _____ Date of Birth for Policy Holder: _____/_____/_____

Primary Medical Insurance: _____ Policy Number:_____

Primary Vision Insurance: _____ Policy Number: _____

HEALTH HISTORY

Current Medication: _____

	Diabetes		High Cholesterol		Double Vision
	Heart Disease		Frequent Headaches		Spot/ Light Flashes
	Thyroid Problems		Arthritis		Glaucoma
	High Blood Pressure		Eye Injury		Cataracts
	Eye Infection		Lazy Eye/ Amblyopia		Retinal Problems
	Eye Surgery		Other		

Drug Allergies: _____

FAMILY HISTORY

	Diabetes		Glaucoma		Macular Degeneration
	High Blood Pressure		Eye Disease		Cataracts

PUPIL DILATION

Pupil dilation is a process where several drops are instilled into the eye to open the pupils. This is recommended for ALL patients. Side effects include decreased vision, light sensitivity and decreased ability to read. This lasts 4 to 6 hours.

POLICY STATEMENT FOR PATIENT CARE SERVICES

We appreciate you choosing Low Country Eye Care. We are dedicated to serving the diverse health needs of our community and are committed to providing you with the very best care.

As our patient, you are responsible for the payment of all services rendered at the time of your visit. We file insurance claims as a courtesy to our patients, but the bill is your responsibility. In the event that there remains a balance due after your insurance carrier has paid its portion, we will bill you and expect payment within 10 days from the receipt of the bill. You are considered a Self-Pay Patient if an insurance provider does not cover you. Payment is required in full at the time services are rendered unless other arrangements are made. It is very important, and your sole responsibility, to keep us informed of your mailing address, telephone number, emergency contact, and any other information that we need in order to provide you with the highest level of service.

After Hours Policy

Our office does not have 24 hour emergency access/call.

If you have an eye emergency after our office hours of 9AM-5PM Monday-Friday please call 911 or go to the nearest Emergency Room.

Insured Patients

If you have insurance and we file on your behalf, you are required to pay your copayment and deductible at the time of your visit. In the event that there remains a balance due after your insurance carrier has paid its portion, we will bill you and expect payment within 10 days from the receipt of the bill. You are considered a Self-Pay Patient if an insurance provider does not cover you. Payment is required in full at the time services are rendered unless other arrangements are made.

If your exam reveals a medical condition or disease related to your eye that requires specific follow up care, regular monitoring or referral to a surgeon, you have a complaint related to a non-refractive nature or if the exam is related to a medical condition, such as cataracts, glaucoma, diabetes, dry eyes, etc., then your visit is NOT COVERED by your vision plan.

Authorization For Release of Medical Information

You authorize Low Country Eye Care to release medical information pertinent to the payment of medical expenses incurred by the insurance carriers named. I authorize a copy of this authorization to be used in place of the original request for payment of medical insurance benefits whether to the patient or to the party who accepts assignments.

In addition, your signature authorizes Low Country Eye Care to release medical records to those specialists for whom you have been referred to for extended medical care. This will only occur when it is medically necessary in managing your overall health care needs. We will not under any circumstances sell your information to a third party for marketing or fundraising purposes without your written consent.

I authorize Low Country Eye Care to communicate with the following party on my behalf:

_____	_____	_____
Authorization for Release of Medical Information	Relationship	Phone Number

Assignment of Insurance Benefits
Your signature below also hereby assigns your rights under the named policy of insurance, indicated on your Patient Information Profile, to Low Country Eye Care, and it is not limited to major medical insurance, hospital benefits, sick benefits or injury benefits. In the event a third party is deemed liable for your medical condition, you assign your rights under an insurer, such as auto insurance, workman's compensation insurance, medical, hospital, or disability payments.

Consent for Medical Care

I _____ (patient name) give permission for **Low Country Eye Care** to give me medical treatment.
I allow **Low Country Eye Care** to file for insurance benefits to pay for the care I receive. I understand that:

- **Low Country Eye Care** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I Understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Appointments
We serve our patients on an appointment basis and require each patient to keep their appointment. However, we understand that there are times when an appointment cannot be kept. In those times we ask that you call in advance to cancel or reschedule your appointment so another patient may be seen. Failure to cancel or reschedule a scheduled appointment will result in a No Show Fee.

Account Status
Please keep your account current. Communication is the key and our Patient Advocates are here to assist you. Thank you for visiting us today, your signature below is acknowledgment in your receipt of this policy and the acceptance of your responsibility.

HIPAA
Your signature below indicates that you have received and reviewed a copy of the revised Health Insurance Portability and Accountability Act (HIPAA) notice. We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we have on file. Copies of this Notice are available upon request and can be found on our website, www.lowcountryeye.com,

Notice Revised and Effective October 25,2023.

_____ _____
Patient Name (Print) Date

_____ _____
Signature of Patient/ Parent/ Guardian Relationship to Patient