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PATIENT INFORMATION

PLEASE PRINT

Patient Name _____ (Last First Middle) Home Tel. _____ Bus. Tel. _____

Address _____ (Street City State Zip) DOB: _____ Soc. Sec # _____ Sex: _____

Employer _____ Address _____ (Street City State Zip)

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian ☐ Declined to Specify

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to Specify

Email _____ Cell Phone _____

Preferred Method of Contact for Appointment Reminders:

Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐

Name of Spouse _____ Spouse's Employer _____ Telephone _____

In Emergency Contact: _____ (Name Telephone Relationship)

RESPONSIBLE PARTY

Name _____ ☐ Self ☐ Parent ☐ Other _____

Address _____ (Street City State Zip) Home Tel. _____ Bus. Tel. _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

SS# _____ DOB _____ Sex _____ SS# _____ DOB _____ Sex _____

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. However, financial agreement rests with you and not the insurance company. Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the Columbia Eye Clinic, P.A/Columbia Eye Surgery Center, Inc. for services rendered.

Date _____ Signature _____

OVER →

CONSENT FOR TREATMENT

I hereby agree and give consent to the treating physician and employees of Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

Patient's/Parent's/Representative's Signature Date

Witness Signature Date

Printed Patient's or Representative's Name

Relationship to Patient

AUTHORIZATION/RELEASE

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. I hereby assign to Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. all payments for treatment services. ***I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.***

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICE and understand my rights contained in the notice. I hereby authorize the release of medical information to Medicare, Medicaid and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

Patient's/Parent's/Representative's Signature Date

Witness Signature Date

Printed Patient's or Representative's Name

Relationship to Patient

FINANCIAL POLICY

I have read and understand the FINANCIAL POLICY of the Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. and I agree to abide by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time-to-time by the practice.

Patient's/Parent's/Representative's Signature Date

Witness Signature Date

Printed Patient's or Representative's Name

Relationship to Patient