The eye Center, P.A.

Beau T. Bryan, M.D.
Matthew T. Clary, M.D.
R. Brian Huff, M.D.
Chip Platt, D.O., F.A.A.O.

1655 Bernardin Avenue . Columbia, SC 29204
Phone: (803) 256-0641 . Fax: (803) 779. 3649
Email: info@eyeseenaturally.com
www.eyeseenaturally.com

PATIENT INFORMATION *(please print)*

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Marital Status: ☐Single ☐ Married ☐ Divorced ☐Widowed			

TODAY'S DATE

Email Address:	Driver's License #:	Birth Date:	Age:	Sex: ☐ M ☐ F

Race: ☐ African American ☐ Asian Pacific ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Street Address:	Social Security #: - -	Home Phone: ( ) -
City:	State:	ZIP Code:	Mobile Phone: ( ) -
Occupation:	Employer:	Employer Phone: ( ) -
Employer Address:		
Spouse or Parent *(if dependent or minor)*:	Social Security #: - -	Birth Date
Spouse or Parent Employer:		Employer Phone: ( ) -

INSURANCE INFORMATION *(please give your insurance card and current drivers license to the receptionist)*

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance:			Insured's Name:	Birth Date
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Secondary Insurance *(if applicable)*:			Insured's Name:	Birth Date
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Primary Care Physician:				Physician Phone: ( ) -

EMERGENCY INFORMATION

Emergency Contact Name:		Emergency Contact Phone: ( ) -	
Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

HOW WHERE YOU REFERRED TO US?

Referring Physician:	Specialty:	Referring Physician Phone: ( ) -
Family, Friend or Acquaintance:		

☐ TV	☐ Newspaper	☐ Magazine	☐ Internet	☐ Close to Home / Work
☐ Yellow Pages	☐ Other			

FINANCIAL POLICY

The above information is true to the best of my knowledge. Payment is due at the time of service for all co-pays, deductibles, and non-covered services. We will file all participating insurance for all covered services. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Eye Center, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

The eye Center, P.A.

Beau T. Bryan, M.D.
Matthew T. Clary, M.D.
R. Brian Huff, M.D.
Chip Platt, D.O., F.A.A.O.

1655 Bernardin Avenue . Columbia, SC 29204
Phone: (803) 256-0641 . Fax: (803) 779. 3649
Email: info@eyeseenaturally.com
www.eyeseenaturally.com

Assignment of Benefits

Medicare

I request that payment of authorized Medicare benefits be made on my behalf to The Eye Center; P.A. for services furnished me by The Eye Center, P.A. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Eye Center, P.A. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MediGap

I understand that if a MediGap policy or other health insurance is indicated on Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to The Eye Center, P.A., if possible or otherwise to me.

Release of Information

The Eye Center, P.A. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable or under contract to The Eye Center, P.A. for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Eye Center, P.A. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Other Insurance

I understand that The Eye Center, P.A. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that The Eye Center, P.A. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by The Eye Center, P.A. if I belong to a plan that does not appear on the above mentioned list.

Non-Covered Services

I understand that The Eye Center, P.A.'s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with The Eye Center, P.A. to obtain necessary health care service plan authorizations.

Financial Agreement

I agree that in return for the services provided to the patient by The Eye Center, P.A., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to The Eye Center, P.A. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to The Eye Center, P.A. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to The Eye Center, P.A. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signature on File

Beneficiary Name (please print) _____ *Medicare Number* _____

Beneficiary or Authorized Party Signature _____ *Date* _____