Carolina Ophthalmology - *Patient Information Sheet*

Date: _____ Name: _____ SS # ___-___-____
Last First Middle/Maiden

Mailing Address: _____
Street City State Zip Code

Street Address: _____
Street City State Zip Code

DOB: ___/___/____ Home Phone: _____ Work Phone: _____

Employer: _____
Name Address

Emergency Contact: _____
Name Phone Relation

Is this your first visit to our office? Y N If yes, referred by: _____

Please provide your health insurance information:

Primary Insurance Company: _____

Policy #: _____ **Group#:** _____

Subsciber Name (if different): _____
Last First Initial Date of Birth

Subscriber SS# _____

Secondary Insurance Company: _____

Policy #: _____ **Group#:** _____

Subscriber Name (if different): _____
Last First Initial Date of Birth

Subscriber SS# _____

Signature on File, Assignment of Benefits, Financial Agreement

1. Medicare: By my signature below and where applicable, I request that payment of authorized Medicare benefits be made on my behalf to Carolina Ophthalmology, P.A., for services furnished to me by Carolina Ophthalmology, P.A. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Carolina Ophthalmology, P.A. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. I understand that if a MediGap policy or other health insurance is indicated for my care, my signature authorizes payment of these secondary insurance benefits be made on my behalf to Carolina Ophthalmology, P.A., if possible or otherwise to me.

2. Other Insurance: I understand that Carolina Ophthalmology, P.A. maintains a list of health care service plans with which it contracts, such list being available from the business office. And that Carolina Ophthalmology, 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 Carolina Ophthalmology, P.A. if I belong to a plan that does not appear on the above mentioned list.

(OVER)

3. Non-covered services: I understand that Carolina Ophthalmology, 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 service plan. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health insurance plan not to be covered. The undersigned agrees to cooperate with Carolina Ophthalmology, P.A. to obtain necessary health care service plan authorizations for services/treatments.

4. Release of Protected Health Information: I have received a copy of Carolina Ophthalmology, P.A.'s Notice of Privacy Practices and understand their policies as well as my rights as it applies to use and disclosure of my confidential medical information.

5. Financial Agreement: I agree that in return for services provided by Carolina Ophthalmology, P.A., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Carolina Ophthalmology, P.A. for payment. If an account is sent to an agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits under any health insurance policy insuring the patient are hereby assigned to Carolina Ophthalmology, P.A. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Carolina Ophthalmology, P.A. I further understand and agree that failure to pay amounts owed in full at the time of service could result in an additional administrative processing fee being charged to my account. **It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I agree to pay, in a timely manner, for any and all charges for services rendered by Carolina Ophthalmology, P.A. that are denied for payment by my health insurance plan.**

_____ _____

Beneficiary Signature or Authorized Party **Date**

(Please do not complete below unless instructed by our front desk staff)

I have reviewed the information provided on this form. I would like to submit the following changes (if no change, write "No Change"):

_____

_____

_____

I have reviewed the information provided on this form. I would like to submit the following changes (if no change, write "No Change"):

_____

_____

_____

I have reviewed the information provided on this form. I would like to submit the following changes (if no change, write "No Change"):

_____

_____

_____