The Retina Center of Charleston, P.A.

Name: ____ **Date of Birth:** _____/_____/_______
First M. Last

Address: ____ **Home Phone:** (_____)__________

____ **SS#** ______-______-______
City State Zip Code

Place of Employment: ____________________________ **Work#:** (_____)__________ext_____

Email Address: ____

Spouse Name: ________________________________ **Date of Birth:** _____/_____/_______
(Parent name if patient is a minor)

Em Contact: ______________________ **Relationship:** _________ **Phone:** (____)__________

Referring Doctor: ______________________________ **City:** ____________________________

INSURANCE: WE WILL FILE WITH YOUR INSURANCE IF WE PARTICIPATE WITH YOUR INSURANCE PLAN. YOU WILL BE RESPONSIBLE FOR YOUR CO-PAYMENT, DEDUCTIBLE, AND ANY NON-COVERED FEES THE DAY THE SERVICE IS PROVIDED. **It is your responsibility to provide our office with your insurance information and any required authorizations necessary to file your claim.**

Primary: ______________________________ **Policy #:** ______________________

Secondary: ____________________________ **Policy #:** ______________________

SELF-PAY PATIENTS: **ALL FEES ARE DUE AT THE TIME OF SERVICE** UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE. THERE IS A 35% HANDLING FEE FOR THOSE ACCOUNTS THAT ARE TURNED OVER TO A COLLECTION AGENCY.

I authorize release of my medical information to my insurance group in order to secure payment of services rendered. It is my responsibility to inform the office of any changes in my insurance coverage and/or personal information.

I have reviewed the above fees/insurance policy and understand that I am responsible for all charges for services provided.

SIGNED: ____ DATE: ________________

PRINT NAME: ______________________________________