Advanced Eye Care
Of the Upstate, P.A.

10 Enterprise Blvd.
Ste 208
Greenville, SC 29615
(864) 254-6070

Patient Registration Form

Date: _____ **SS#**_____

Patient Name: _____
Last First Middle

Home Address: _____
Street No. Street Name Apt#

_____
City State Zip

Home Phone: _____Cell# _____ _____Nickname: _____
Date of Birth: _____Age:_____
Employment: ____Full Time ____Part Time ____Retired ____None: Marital Status(circle) S / M / D / W
Patient Relationship to Policy Owner: ___Self ___Spouse ___Other: Student: ___Full Time ___Part Time
Patient Employer: _____
Name Address

Business Phone#: _____E-Mail:_____
Primary Care Physician Name:_____ Phone #: _____
Referring Physician Name:_____ Phone #: _____

ATTENTION:

PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR PART OF THE CHARGES".
WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS AS WELL AS CHECKS AND CASH.

Pharmacy Name:_____ Phone #: _____
Emergency Contact Name:_____ Phone #: _____

INSURANCE INFORMATION:

Primary

Insurance Co Name: _____
Insurance Address: _____
Name of Insured: _____
DOB of Insured: _____
Insured's SS#: _____
Insured's ID#: _____Group#_____
Insured's Phone#: _____
Employers Name: _____
Employers Address: _____
Employers Phone#: _____

Secondary

Insurance Co Name: _____
Insurance Address: _____
Name of Insured: _____
DOB of Insured: _____
Insured's SS#: _____
Insured's ID#: _____Group#_____
Insured's Phone#: _____
Employers Name: _____
Employers Address: _____
Employers Phone#: _____

How did you hear about us?

☐ Radio ☐ Journal ☐ Newspaper ☐ Yellow Pages
☐ Website ☐ Patient Referral ☐ Physician Referral ☐ Other

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Patient Information Form

Name: _____ **Chart#:** _____

Reason for Visit (Please Be Specific). Insurance will not pay for routine exams:

_____

_____

Medical, Eye & Family History

Please check if you have any of the following. If yes, how long or what type?

Macular Degeneration	☐ _____	High Blood Pressure	☐ _____
Cataracts	☐ _____	Diabetes	☐ _____
Retinal Detachment	☐ _____	Asthma	☐ _____
Glaucoma	☐ _____	Emphysema	☐ _____
Lazy Eye	☐ _____	Heart Disease	☐ _____
Eye Injury	☐ _____	Cancer	☐ _____
Other Eye Problems	☐ _____	Pregnant	☐ _____
		Other Problems	☐ _____

Does anyone in your immediate family have any of the above problems or diseases? If so which ones? _____

_____

Have you ever had any eye surgery? If yes, what type, when and by whom? _____

_____

If you wear glasses or contacts, when was your last prescription change? _____

When was your last eye examination? _____By whom: _____

Name of your Family Physician: _____

Social History

Do you use alcohol? _____ If yes how much? _____ Do you use Tobacco Products? _____ If yes how much? _____

Hobbies: _____

Occupation: _____ Marital Status: ☐ Married ☐Single ☐Divorced ☐ Widowed

Systemic Review of Symptoms

Please check all that apply to you:

Weight Loss or Gain	☐	Mental Health Problems	☐	Frequent Urination	☐
Loss of Smell	☐	Double Vision	☐	Painful Joints	☐
Shortness of Breath	☐	Chest Pain	☐	Skin Rashes	☐
Numbness/Headaches	☐	Intestinal Problems	☐	Diabetes	☐
Easy Bleeding	☐	Allergies	☐	Thyroid Problems	☐

List all Allergies to any medications and your reaction: _____

_____

Current Medications (including aspirin, blood thinners & Eye medications)

Medication	Dosage	Times per Day	Medication	Dosage	Times per Day

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Release of Medical Information Authorization Form

STEP 1: INFORMATION ABOUT YOU:

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Phone Number: _____
Complete Address: _____

STEP 2: WHERE ARE YOUR MEDICAL RECORDS?

I hereby authorize:

STEP 3: TO WHOM DO YOU WISH TO RELEASE YOUR MEDICAL RECORDS?

To release my medical records to: _____
Name of Facility, Doctor or Person

_____
Complete Mailing Address

STEP 4: INFORMATION TO BE RELEASED:

- ☐ Complete Medical History (3 years medical records will be provided unless otherwise requested)
- ☐ Medical Records for Time Period From: _____ To: _____
- ☐ Other: _____

STEP 5: THIS DISCLOSURE IS BEING REQUESTED FOR THE FOLLOWING REASON:

☐ Continuing Care	☐ Insurance/Disability Coverage	☐ Other
☐ Legal Action	☐ Worker's Compensation Case	_____
☐ Transfer of Care	☐ Personal Reasons	_____

By signing this authorization, I authorize and permit the above designated provider and staff members to use and/or disclose certain protected health information (PHI) about me to the party or parties listed above. **THIS AUTHORIZATION EXPIRES TWENTY YEARS FROM DATE SIGNED, UNLESS OTHER PERIOD IS DESIGNATED: _____ (INITIALS).** I understand that I have the ability to revoke this authorization by providing the practice with a written revocation unless the practice has already disclosed the PHI relying upon this authorization. Should I desire to revoke this authorization, my revocation must be in writing and sent to Advanced Eye Care of the Upstate, P.A., 10 Enterprise Blvd. Ste 208 Greenville, SC 29615. I understand that the PHI disclosed pursuant o this authorization may no longer be protected by Federal privacy Law. I further understand that Advanced Eye Care of the Upstate, P.A. will not condition my treatment, payment and enrollment in a health plan of eligibility for benefits, if applicable, based on the execution of this authorization and that my participation is voluntary. **PATIENTS REQUESTING COPIES OF THEIR PHI FOR PERSONAL REASONS WILL BE CHARGED. COPYING FEES WILL APPLY TO, BUT ARE NOT LIMITED TO, LEGAL ACTIONS AND INSURANCE DISABILITY FORMS. PAYMENT IS DUE PRIOR TO PHI BEING RELEASED.** Copying fees do not apply to other medical providers or healthcare facilities that receive PHI directly.

_____ _____
Patient Signature/Legal Representative **Date:**

Relationship to Patient:

☐ Legal Guardian ☐ Certified Personal Representative ☐ Power of Attorney for Healthcare ☐ Other: _____

_____ _____
Witness **Date:**

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Financial Responsibility & Notice of Privacy Practice Form

DO WE HAVE PERMISSION TO:

- Leave a message on your answer machine at home? ☐ Yes ☐ No
- Leave a message at your place of employment? ☐ Yes ☐ No
- Discuss your medical condition with any member of your household? ☐ Yes ☐ No
- If yes, Whom: _____
- Relationship: _____

Patient Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE / RELEASE AND ASSIGNMENT OF BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures; others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. If we are filing your claim we will allow forty days from the billing date for the carrier to process your claim and make payment accordingly. If payment from your insurance company is not received within the time frame specified above, you will be billed for the balance. Insurance billing is done as a courtesy to the patient and does not dismiss patient's responsibility.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions or the patient's record. I hereby assign all medical records and/or surgical benefits, to include major medical benefits to which I am entitled, including MEDICARE, PRIVATE INSURANCE, WORKERS COMPENSATION, AND OTHER HEALTH PLANS to Advanced Eye Care of the Upstate, P.A. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges. This assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance company unless dictated by the insurance company that there is a contractual write-off. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I understand that while I am a patient of Advanced Eye Care of the Upstate, P.A. I may be referred to a non-Advanced Eye Care of the Upstate, P.A. physician or healthcare facility for treatment, consultation, or diagnosis which my physician believes is a necessary part of my medical care. I hereby authorize Advanced Eye Care of the Upstate, P.A. to release any and all medical records and information which may be required for the continuation of my medical care during the course of referral. A photocopy of this release shall have the same effect as the original. This release shall remain in effect until revoked by me or my legal representative in writing.

I certify that I have read and understand fully the providers billing policy and agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above.

_____ _____
Patient Signature/Legal Representative **Date:**

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

By signing this form I acknowledge that I have been given the opportunity to review Advanced Eye Care of the Upstate, P.A. Notice of Privacy Practice, and informed that I may obtain a copy upon request to keep as reference.

_____ _____
Patient Signature/Legal Representative **Date:**