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

The eye Center, P.A.

1655 Bernardin Avenue
Suite 100
Columbia SC 29204
803-256-0641

Patient Info:

◯ Male
◯ Female

Name: _____
FIRST MIDDLE LAST

Street Address: _____

City:_____ **State:** _____ **Zipcode:** _____

Birth Date: _____ **Age:** _____ **Social Security Number:** _____

Race: ◯ Caucasian ◯African American ◯American Indian ◯Asian ◯ Hispanic ◯ Other: _____ ◯ Decline

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Partner ◯ Legally Separated

Home Phone : _____ **Cell:** _____ **Work:** _____

Preferred method of contact: ◯Home Phone ◯Cell Phone ◯ Work Phone

Email Address: _____

Employment Status: ◯Full Time ◯ Part-time ◯Retired ◯Self Employed ◯ Active Military ◯Unknown

Employer: _____

Primary Care Physician (Family Doctor): _____ Phone Number: _____

How were you referred to us? Referring Physician: _____ Specialty: _____

Other: _____

Insurance:

Are you covered by insurance? ◯ Yes ◯ No

Primary Insurance: _____

Policy Holder: _____ DOB: _____ SSN: _____

Secondly Insurance: _____

Policy Holder: _____ DOB: _____ SSN: _____

Tertiary **Insurance:** _____

Policy Holder: _____ DOB: _____ SSN: _____

Emergency Contacts:

Name:_____ **Relationship:** _____ **Phone:** _____

Name:_____ Relationship: _____ Phone: _____

Assignment of Benefits & Financial Responsibility

The physicians and staff of The Eye Center, P.A. are committed to providing the best specialized eye care and treatment for our patients, and we charge what is usual and customary for our area.

Insurance: We participate with many health plans, and we will file your claim with your insurance company. If we do **NOT** participate with your insurance company we will file your claim for your convenience; however you are responsible to pay the entire fee in full at time of service. If your health plan determines a service to be 'not covered', or you fail to provide the correct insurance information at the time of your visit, you will be responsible for the complete charge.

Self-Pay Services: If you do not have insurance, or we do not participate with your insurance plan, you are responsible for all charges. We can ONLY offer a discount when you pay your balance at the"time of service".

Surgery: If you are having surgery we will obtain pre-certification, if necessary, and verify your insurance benefits including the amount you will owe in addition to the payment by your insurance. **We require all deductible and co-insurance amounts to be paid prior to the date of your surgery.** Payment for services and upgrade lenses not covered by insurance must be paid in advance of the services rendered. We will not finance your balance by accepting monthly payments; however we offer finance options through CareCredit and Regions Bank.

Optical: Glasses and sunglasses will be dispensed once full payment is received.

Past Due Account Balances: Your account is considered past due when the unpaid balance is not paid within 30 days. Past due accounts are sent to a collection agency after 90 days. **Past due accounts must be paid in full before a return appointment can be made**.

Authorization: I authorize and request the payment of services and treatments from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to The Eye Center, P.A. I understand that it is my responsibility to supply The Eye Center, P.A. with any current insurance information and/or any referral authorization forms that may be necessary for my insurance. **I understand that insurance companies require beneficiaries to pay deductibles, co-payments, and any non-covered services at the time services are rendered.**

Refraction (eyeglass prescription): I understand that **my health insurance does not cover eye refraction**, and I am fully responsible to pay for this service at time-of service. Receipt available upon request for "vision insurance". **The current fee for this service is $40.00**.

I understand that a comprehensive eye exam involves dilation of the pupil, which may temporarily blur my vision for several hours. I recognize that operation of a motor vehicle after dilation may be hazardous and I have made appropriate arrangements.

We accept cash, check, VISA, MC, AMEX & Discover. We also offer CareCredit and Regions Bank's deferred interest and interest bearing finance options. If your check is returned for non-sufficient funds, a returned check fee of $25.00 will be applied to your account balance.

I have read and understand the FINANCIAL POLICY of The Eye Center, P.A., 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 Signature/Legal Guardian **Date**