Patient Registration Information

Name: ______________________________ DOB: ___________ SSN: ____________________

Address: ____

City: __________________________ State: ____________________ Zip Code: ____________

Gender (circle one): F / M Marital Status (circle one): Single Married Widowed Other

Responsible Party: Self or Other: __________________________ Relationship: _______________

Home phone: ________________ Cell phone: ________________ Work phone: _______________

Email: ____

Patient Employer: ______________________________________ Phone: _______________

Emergency Contact: ____________________________________ Relationship: _______________

Phone: ____________________ Email: ____

Eye Physician: _________________________ Primary Care Provider: ________________________

Cause of Eye Loss (Disease/Trauma/Birth Defect) (*insurance required information*): ________________

___________________________ Date of Injury: _________________ Date of Surgery: __________

Primary Insurance: ___________________________ ID# _________________ Group# __________

Policy Holder: ____ Policy Holder DOB: _____________

Secondary Insurance: _________________________ ID# _________________ Group# __________

Policy Holder: ____ Policy Holder DOB: _____________

Authorization to Release Information: I authorize **Southeastern Ocularists, Inc.** to release information and medical records to insurance carriers or physicians during the course of my examination and treatment.

Assignment of Benefits: I hereby assign **Southeastern Ocularists, Inc.** all payments for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this original shall be considered valid as the original.

Financial Agreement: We request that payment be made at the time professional services are rendered. Any services not paid for in full at time of the visit must be coordinated with insurance. You are responsible for any payments or co-payments not paid by your insurance company.

We are a contracted Medicare provider. If you are covered for prosthetic eyes under your Medicare plan, Medicare will pay you directly 80% of the allowed charge after your yearly deductible with Medicare has been met. You will be responsible for all payments at the time services are rendered, since Medicare will be paying you directly. You will also be responsible for all charges over the Medicare allowed amounts.

A service charge of $25.00 will be charged for all checks returned for insufficient funds or for any other reason.

If you have any questions, please feel free to discuss them with us.

By my signature below, I am agreeing to the Authorization to Release Information, Assignment of Benefits, and the Financial Agreement.

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Signature of Responsible Party   Date