



Patient Registration Information

Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____

Patient Employer: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Eye Physician: _____ Primary Care Provider: _____

Reason for Loss of Eye (Disease/Trauma/Birth Defect): RT / LT _____

_____ 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.

Signature of Responsible Party

Date