EYE CENTER
OF CHARLESTON

PLEASE COMPLETE (ALL INFORMATION IS REQUIRED)

Name _____ ❑ Male ❑ Female DOB ____/____/_____

Mailing Address _____

City, State, Zip _____

Phone Home _____ Cell _____ Work _____

SSN _____ Family Doctor _____

Occupation _____ Employer _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____

E-Mail _____

Patient Status ❑ Married ❑ Single ❑ Divorced ❑ Widow/Widower
❑ Full-Time Student ❑ Part-Time Student

TODAY'S VISIT

How did you hear about us _____

If referred, by whom _____

Routine Vision Plan _____

***or* Medical Reason** _____

Pharmacy used _____ Phone Number _____

INSURANCE INFORMATION

Policy Holder _____ SSN _____ DOB ___/____/_____

Address _____ Phone Number _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Patient's relationship to primary insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

PLEASE READ CAREFULLY

Drs. John C. Kulze III, John Ellyn, Hugh E. Wright III and Charles Beischel are Medicare providers and participate in most insurance plans. Patients will be responsible for any co-payments, deductibles, non-authorized or non-covered services as defined by your individual insurance plan. Patients without a health insurance plan or one in which we do not participate *will be expected to render payment at the time of service unless arrangements have been made in advance.* Upon request a statement will be provided for you to present to your insurance carrier for reimbursement.

I hereby authorize release of my medical information necessary to process insurance claims for services rendered and request that benefits be made either to myself or the party that accepts assignment. I understand that I am financially responsible for all charges not paid by my insurance carrier. A copy of this authorization shall remain on file for all future treatment. I further authorized said assignee to release all information to secure payment.

I also authorize Drs. Kluze, Ellyn, Wright and Beischel to obtain information form other physicians they feel necessary and beneficial to evaluate and treat my condition. A copy of this authorization will be as valid as the original.

Signature _____ Date _____

Signature _____ Date _____

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OF CHARLESTON

JOHN C. KULZE III, M.D. | JOHN ELLYN, M.D. | HUGH E. WRIGHT III, M.D. | CHARLES BEISCHEL, M.D., PH.D.
Comprehensive Ophthalmology, Cataract, Glaucoma, Diabetes and Routine Eye Care

TO OUR PATIENTS

Testing for glasses prescriptions is considered "Routine" by most insurance companies and is a non-covered service.

A refraction may be required by your physician for diagnostic testing.

If your physician deems it necessary on your visit today,
we will ask you to pay $40 when you check out.

In the event that your insurance does cover all or a portion of our fee,
we will refund that amount to you.

Co-payments, deductibles and non-medical (vision care as stated by insurance carriers) will be collected at the end of your visit.

Please do not ask to be billed.

_____

Patient Signature

_____

Today's Date

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ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

This will acknowledge that I have been informed of the **Eye Center of Charleston Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____ _____

Signed Today's Date

If not signed by patient, please indicate relationship to patient (e.g., spouse)

_____ _____

Relationship Witnessed by

FOR OFFICE USE ONLY

If patient of patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

_____ _____

Presented on (Date and time) By (Name and title)