

PLEASE COMPLETE (ALL INFORMATION IS REQUIRED)

Name: _____ Sex: _____ Birth Date: _____

Mailing Address: _____ Phone: Home: _____

City, State, Zip: _____ Cell : _____

SSN: _____ Occupation: _____

Family Doctor: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact: _____

Patient 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 #:** _____

Insurance Information

Name of Policy Holder: _____ SSN: _____ DOB: _____

Address: _____ Telephone: _____

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, Sudeep K. Das, Charles Beischel and Robert J. House 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 authorize said assignee to release all information to secure payment.

I also authorize Drs. Kulze, Ellyn, Das, Beischel and House to obtain information from 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 _____

Signature _____ Date _____

Signature _____ Date _____



EYE CENTER

OF CHARLESTON

JOHN C. KULZE III, M.D. | ROBERT J. HOUSE, M.D. | CHARLES J. BEISCHEL, M.D., PH.D | JOHN ELLYN, M.D. | SUDEEP K. DAS, M.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 \$50 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

CERTIFIED BY AMERICAN BOARD OF OPHTHALMOLOGY

PRIMARY OFFICE: 2270 Ashley Crossing Dr. | Suite 100 | Charleston, SC 29414 | 843.556.2357 | Fax 843.556.0350

ROPER ST. FRANCIS MEDICAL CENTER: 149 St. James Avenue | Goose Creek, SC 29445 | 843.556.2357



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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 or 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)

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