



Account Number: _____
Date: _____

Referring Doctor: _____ Primary Care Doctor: _____

PATIENT INFORMATION					
Patient's Name (First Middle Last)				Nickname	
Social Security No.	Date of Birth	Age	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Street Address				Email Address	
City	State	ZIP code	Home Phone Number ()	Mobile Phone Number ()	
Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> None			Student: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a student		
Employer/School Name		Employer/School Address			
City	State	ZIP code	Employer Phone Number ()		

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)					
Name (First Middle Last)				Relationship to Patient	
Social Security No.	Date of Birth	Age	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Street Address				Email Address	
City	State	ZIP code	Home Phone Number ()	Mobile Phone Number ()	
Employment: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> None			Student: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a student		
Employer/School Name		Employer/School Address			
City	State	ZIP code	Employer Phone Number ()		

INSURANCE INFORMATION	
Please Check One: <input type="checkbox"/> Patient IS the policy holder <input type="checkbox"/> Patient IS NOT the policy holder <input type="checkbox"/> Self Pay	
Primary Insurance Company	Policy Number
Secondary Insurance Company	Policy Number
Check Any That Apply: <input type="checkbox"/> Residence is a Skilled Nursing Home <input type="checkbox"/> Insurance is provided through the Veterans Admin.	

I certify that the above information is correct to the best of my knowledge.

Patient or Responsible Party **Signature:** _____ **Date:** _____



Account Number: _____

Date: _____

MEDICAL HISTORY

Has the patient ever been diagnosed with any medical problems? Yes No

If yes, please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Autoimmune disorder (lupus, rheumatoid arthritis) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer (please specify _____) | <input type="checkbox"/> High Cholesterol | |

List any other medical illnesses: _____

List any past surgeries or hospitalizations (include dates): _____

Has the patient ever been diagnosed with or treated for eye problems? Yes No

If yes, please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Amblyopia ("lazy eye") | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Vascular Disease |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Dry <input type="checkbox"/> Wet | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Pucker | <input type="checkbox"/> Uveitis (inflammation) |

List any other eye problems: _____

List any previous eye surgeries or laser treatments (include dates): _____

Please list any ALLERGIES: _____

Please list any current MEDICATIONS (See attached list or None): _____

Do you have a preferred PHARMACY?

Name: _____ Phone Number: _____

Does the patient have a family history of any medical or ocular problems? Yes No

If yes, please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cataract | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Cancer
(please specify _____) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |

Do you smoke? Yes No Previously

Do you drink alcohol? Yes No Previously

Do you use recreational drugs? Yes No Previously

Occupation: _____

Have you recently had any of the following symptoms? (Please check all that apply) None

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Neurologic symptoms
(headache, seizures, numbness) | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> GI symptoms (diarrhea, reflux, etc.) | <input type="checkbox"/> Pain in muscles or joints | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Other (please describe to technician) | | |



Patients or the Responsible Party MUST sign and date all paragraphs below before medical care can be rendered.

Insurance Information

The information regarding my insurance coverage is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Retina Institute of the Carolinas or the insurance company to release any information required to process my claims.

Signature: _____ Date: _____

Privacy Practices Acknowledgement (HIPAA)

Retina Institute of the Carolinas' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent, and it is always available at the check-in desk. As provided within our Notice, the terms may change, and if so, you may obtain a revised copy by contacting our main office at 803-323-2020.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do agree, we are bound by our agreement.

By signing, you acknowledge that you have read our Notice and consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

Signature: _____ Date: _____

Release of Medical Information

I authorize the release of medical information to my primary care physician or referring doctor, to consultants if needed, and to the following designees:

- 1) _____ 3) _____
- 2) _____ 4) _____

Signature: _____ Date: _____



Patient Financial Responsibility Agreement

In order for Retina Institute of the Carolinas to continue providing quality medical care to our patients, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our **patient's responsibility**. To this end, we expect our patients to:

Pay all charges not covered by your insurance, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised. If this is not possible, you are expected to **inform our business office before services are rendered**.

Provide us with a copy of your most recent insurance card or other proof of insurance at the time of **each service**. If you do not provide us with this information at **each service**, you agree to **personally pay all unpaid charges**.

Obtain any authorization required under you insurance plan from your primary care physician and/or your insurer prior to each service appointment with us. If you do not receive the required authorization your insurer may not pay us for our services. In these cases, you agree to **personally pay any resulting unpaid charges**.

Monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding their nonpayment and to cooperate with Retina Institute of the Carolinas to resolve the unpaid status of your account. Overpayments will not be returned unless requested by the patient.

By signing this agreement, you agree that Dr. Samiy, Dr. Farr, Dr. Tucker, and the Retina Institute of the Carolinas have the right to be paid for their services, and you acknowledge that unpaid bills older than 90 days from the date of service may be turned over to a debt collection agency or attorney for collection. You agree that you will be responsible for any resulting collection fees, including reasonable attorney fees and/or bank fees incurred as a result of a returned check.

I acknowledge that I have read and understand the Patient Financial Responsibility Agreement and agree to the provisions there-in.

Signature: _____ Date: _____