EYE ASSOCIATES
OF LITTLE RIVER, LLC

Welcome to our practice

Today's Date: ____/____/_____

Name: _____
First MI Last

Birthdate: __ / __ / ____ Age: _____ SS#____-____-_____

Race: _____ Ethnicity: _____ Gender: M / F

Mailing Address: _____

_____

Physical Address: _____

_____

Home Phone :(_____) _____-_____

Cell Phone :(_____) _____-_____

Work Phone :(_____) _____-_____ EXT: _____

E-mail Address_____

Status: ☐single ☐ married ☐ divorced ☐ widowed

Occupation: _____

How did you learn about Eye Associates of Little River?

_____

How may we contact you? Please check all that apply:

☐ home ☐ cell ☐ work ☐ email

In case of emergency, whom do we contact?

_____ Phone: (____) _____-_____

To whom may we release medical information?

_____ Relationship: _____

Is the patient currently enrolled in hospice care? Y / N

Is there a power of attorney or legal guardianship? Y / N

I understand Eye Associates of Little River, LLC participates in HIPAA Compliance and I have access to my HIPAA rights and office policy. Policy is posted and available in office.
I understand that Eye Associates of Little River, LLC will provide any protected health information that I request upon completion of a signed records release form.

X: _____

Insurance Information

Please present insurance cards to staff and photo ID.

Insurance may not be filed retroactively.

We are not an in-network provider for all insurance plans. It is your responsibility to know your coverage, network, and if a referral is needed.

Routine VISION Insurance

Company Name: _____

Name of Insured: _____

Relationship: _____ Birthdate: ___/___/_____

SS No. of Policy Holder: _____

Primary MEDICAL Insurance

Company Name: _____

Name of Insured: _____

Relationship: _____ Birthdate: ____/____/____

SS No. of Policy Holder: _____

☐ **Check if you have a secondary medical insurance.**

Authorization for Payment

I am authorizing assignment of my insurance rights and benefits directly to Eye Associates of Little River, LLC for services rendered and materials provided. I fully understand that I am responsible for any charges that may be denied or not covered by my insurance company.

X: _____

All fees are due at time of service unless assignment has been approved by your vision/medical insurance. Fees include copays, deductibles, refractions fees, contact lens fees, etc. We do not participate in payment plans. Accounts with open balances will not be seen until account is satisfied. Collections and returned check fees apply. Accounts will be sent to collections after 120 days.

Consent for Treatment

By signing this form, I consent to treatment for the patient. I give my permission for the doctor to examine, diagnose, and indicate treatment as deemed appropriate. I understand that my doctor will answer any questions to the best of their ability and I will be given an option to consent to any and all treatment.

X: _____

HABITUAL NO-SHOW APPOINTMENTS WILL HAVE CARE TERMINATED