Columbia Eye Clinic

Dear Patient:

Welcome to Columbia Eye Clinic. We are honored that you have chosen us as your health care provider and look forward to meeting you. Our goal is to provide the highest quality professional eye care for all of our patients in a timely and proficient manner.

In order for you to be seen as efficiently as possible, **we'd like to request that you arrive 15 minutes prior to your scheduled appointment time.** This will allow the appropriate time needed to ensure that all required paperwork and insurance information is obtained.

Please review, complete, and bring with you to your appointment the following items:

1. Patient Information Form
2. Consent / Authorization / Financial Policy Form
3. Patient History Form
4. Picture ID
5. Insurance Card(s)
6. Authorization Paperwork ***(if your insurance requires an authorization for coverage of the visit, please obtain this from your primary care physician)***

Payment is due at the time of service. This would include any co-pays, past due/bad debt balances, a self-pay status, services not covered by your insurance, etc.

Please remember that we have reserved this appointment time especially for you. If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance at **803-779-3070** to cancel. We will be happy to reschedule you for another date and time that is more accommodating.

COLUMBIA EYE CLINIC, P.A.
803-779-3070
Toll Free 1-800-922-6057
www.columbiaeyeclinic.com

PATIENT INFORMATION

PLEASE PRINT

Patient Name _____ _____
Last First Middle Occupation

Address _____ DOB: _____ Soc. Sec # _____ Sex: _____
Street City State Zip

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian ☐ Declined to Specify

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to Specify

Email _____ Home Phone _____ Cell Phone _____

Preferred Method of Contact for Appointment Reminders: Home Phone _____ Cell Phone/Text _____ Email _____

Emergency Contact Name: _____
Phone Number: _____

RESPONSIBLE PARTY

Name _____ Relationship _____

Address _____ Telephone Number _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. Howerver, financial agreement rests with you and not the insurance company.

Date _____ Signature _____

HIPAA Release Form – Verbal Only

I authorize the **verbal release** of information including the diagnosis, treatment, testing and examination findings, and claims information from Columbia Eye Clinic, PA & Columbia Eye Surgery Center, Inc. to the following person(s):

NAME	RELATIONSHIP

***This Release of Information will remain in effect until terminated by me in writing.**

Date: _____ Signature: _____

CONSENT FOR TREATMENT

I hereby agree and give consent to the treating physician and employees of Columbia Eye Clinic, PA/Columbia Eye Surgery Center, Inc. and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

AUTHORIZATION / RELEASE

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Columbia Eye Clinic, P.A./Columbia Eye Surgery Center, Inc. I hereby assign to Columbia Eye Clinic, PA/Columbia Eye Surgery Center, Inc. all payments for treatment services. ***I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.***

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICE and understand my rights contained in the notice. I hereby authorize the release of medical information to Medicare, Medicaid and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

FINANCIAL POLICY

I have read and understand the FINANCIAL POLICY of the Columbia Eye Clinic, PA/Columbia Eye Surgery Center, Inc. and I agree to abide by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient's/Parent's/Representative's Signature Date

_____ _____

Printed Patient's or Representative's Name Relationship to Patient