Our Mission Statement:

We improve your quality of life by providing the finest in vision care for people of all ages in the lowcountry

Scheduled Appointments

Appt Date	Time	Reason	Resource

Provider:

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Work Phone

Email Address | Spouse or Parent(s) Name | Person Responsible for Account

Emergency Contact | Emergency Phone

Height ft in cm/m ○ ft in ○ cm ○ m

Weight ○ lbs ○ kg

Race

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African America
☐ Hispanic Or Latino
☐ Native Hawaiian Or Other Pacific Islande
☐ White
☐ Declined To Specify

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

How were you referred to our office?

☐ School ☐ Drive by ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Other: (Please Specify) _____ ☐ Doctor (Please Name) _____

Patient has received HIPAA Privacy Policy? ○ Yes ○ No **Date**

Notes

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to EyeCare Specialties of Charleston. As a courtesy, EyeCare Specialties will bill my primary insurance one time. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

My signature below also authorizes EyeCare Specialites of Charleston to release any medical records to other medical offices, schools, etc. per my verbal request. Since all optical jobs are customized and unique to each patient, we require a 50% nonrefundable deposit day of purchase. A**LL OPTICAL SALES ARE FINAL.**

I ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF EYECARE SPECIALITIES' NOTICE OF PRIVACY PRACTICES

Signature | Date