





# RETINA CONSULTANTS OF SOUTH CAROLINA



## FINANCIAL POLICY

Each patient is responsible for his or her own bill. I hereby authorize Retina Consultants of Charleston to release to my insurance company any information acquired during my examination or treatment.

Payment of all insurance co-payments and/or deductibles are due at the time medical services are rendered. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible, you will need to make payment arrangements with our office prior to any medical evaluation for treatment. We accept cash, checks and major credit cards.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing you must provide all insurance policy information including any changes in coverage to this office. Your bill is your responsibility whether your insurance company pays or not. At times you may need to contact your insurance carrier regarding slow or nonpayment of your insurance claim.

You are responsible for knowing what your insurance covers, your current copay amount and the provider(s)/network(s) covered under your health insurance plan. Any service provided but not covered by your insurance company will be your responsibility to pay.

If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.

A 35.00 fee will be charged on all returned checks.

I understand that this is a binding agreement between myself and Retina Consultants. I understand that I will be held responsible for any outstanding balances.

X \_\_\_\_\_

Signature of patient (Parent/Legal Guardian if a minor)

Date

X \_\_\_\_\_

Witness

Date

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last Eye Exam \_\_\_\_\_ Pharmacy name and number \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

List MEDICATIONS (RX and Over the Counter)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all MAJOR ILLNESSES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to ANYTHING? YES NO

If YES, list the medications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List any SURGERIES you have had

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you CURRENTLY have any problems in the following area? Please circle any that apply and provide additional information.

EYES – Poor Vision, Eye Pain, Tearing, Redness, Other		
GENERAL CONSTITUTION Fever, Heat Stroke, Weight Loss, Weight Gain, Fatigue, Other		
EARS, NOSE, THROAT Hearing Loss, Nasal Congestion, Earache, Cough, Dry mouth, Other		
CARDIOVASCULAR High Blood Pressure, Racing Pulse, Other		
RESPIRATORY Congestion, Wheezing, Shortness of Breath, Other		
GASTROINTESTINAL Nausea, Diarrhea, Constipation, Hernia, Ulcers, Other		
GENITAL/KIDNEY/BLADDER Painful Urination, Frequent Urination, Impotence, Jaundice, Other		
FEMALES Pregnant /Nursing		
MUSCLES/BONES/JOINTS Joint Pain, Stiffness, Swelling, Cramps, Arthritis, Other		
SKIN Pimples, Warts, Growths, Rash, Other		
NEUROLOGICAL Numbness, Headaches, Seizures, Paralysis, Other		
PSYCHIATRIC Anxiety, Depression, Insomnia, Other		
ENDOCRINE Diabetes, Hypothyroid, Other		
BLOOD/LYMPH Bleeding, Cholesterolemia, Anemia, HIV/AIDS, Hepatitis, Other		
ALLERGIC/IMMUNOLOGIC Sneezing, Redness, Itching, Hives, Lupus, Other		

FAMILY HISTORY (Mother, Father, Sibling, Grandparent) Has any member of your family had these diseases (Circle all that apply) BLINDNESS / CATARACT / GLAUCOMA / DIABETES / HYPERTENSION / HEART DISEASE / STROKE / CANCER / THYROID DISEASE / ARTHRITIS other heritable disease \_\_\_\_\_

Does your Vision limit any activities of daily living (reading, driving, sports, work, etc) YES NO

Do you drink alcohol YES NO If yes how much \_\_\_\_\_

Do you smoke YES NO If yes how much \_\_\_\_\_ How many years \_\_\_\_\_