HOLLAND eye center, PC

Patient Registration: MRN: _____

Patient Information:			
First Name:	Last Name:	MI:	Date of Birth:
Address:	City	State:	Zip:
Please check Primary Phone: NUMBER:	Home Phone: ☐ ( ) -	Work Phone: ☐ ( ) -	Cell Phone: ☐ ( ) -
Other Name (s) Used:		E-Mail Address:	
Gender: ☐ M ☐ F	SSN:	Preferred Language:	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact: ☐ Mail ☐ Home Phone ☐ Cell Phone	Race: ☐ American Indian or Alaskan ☐ Asian ☐ Black or Native American ☐ White ☐ Other	
Primary Care Doctor:	Referring Provider:		
Pharmacy:	Pharmacy Location:		

Responsible Party: (Guarantor)		***Same as Patient:*** ☐	
First Name:	Last Name:	MI	Date of Birth:
Address:	City:	State:	Zip:
Please check Primary Phone	Home Phone: ☐ ( ) -	Work Phone: ☐ ( ) -	Cell Phone: ☐ ( ) -
SSN:	Relation to Patient:	Preferred Language:	

Emergency Contact: (For minor child, this section may be used for the other parent)		
First Name:	Last Name:	MI:
Relation to Patient:		
Phone :	( ) -	

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREAT/RELEASE OF INFORMATION: I grant Holland Eye Center, PC, to administer treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agent to process my payments for the service. To the best of my knowledge, all the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Holland Eye Center, PC

_____ _____

Patient/ Guardian Signature Relationship to Patient Date:

Patient Acknowledgement Form for

Patient Name: _____

(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the Holland Eye Center, P.C. to contact or leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes. You will be asked to update this information every 12 months from the date below.

Home telephone: yes_____ no_____ Cell phone: yes____ no_____

Work phone: yes_____ no_____ Email: yes_____ no_____

May we fax and/or email medical records for referrals? yes_____ no_____

Please list names of people with whom we can discuss your medical care:

Spouse Name:_____

Parent Name:_____

Other Name(s) & Relationship:_____

_____

Please list a **"unique identifier"** as a way to confirm your identity when calling the office. This **"unique identifier"** must be given before any information can be disclosed.

Unique Identifier:_____

This can be whatever you choose.

For example you can use the last four digits of your social security number or mother's maiden name.

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative: **Date:**

_____ _____

If Personal Representative, give relationship to patient:

_____

HOLLAND eye center, PC

Financial Policy

Refraction $61.00

The refraction is the portion of the exam that measures your ability to see an object at a specific distance. From the exam chair you will look through a phoropter toward an eye chart. The phoropter contains lenses of different strengths and types that can be moved into view. Our technicians or doctor will ask you which view is clearer as they place difference lenses in front of the eye ("number one or number two).
When you can read the chart the clearest, the technician or doctor will make note of the lenses used. This process takes time and patience due to the interaction required for the most accurate outcome.
You will only be charged the $61.00 fee a t the time of service if you need a new glasses or contact lens prescription. Refractions are a noncovered service under the Medicare program. Other insurance and secondary plans may vary depending on your individual benefit coverage. In our experience, unless you have routine vision coverage, they will not cover the cost of the Refraction. This fee is due at the time of service.

Co-Pays and Deductibles

All co-pays and deductibles will be collected at the time of service. If you are unable to pay your co-pay or deductible, please let our front office staff know and they can assist you with rescheduling your appointment.

No Show Policy $25.00

Please help us better care for you.

There will be a $25.00 fee for a nocall, or no show missed appointment.

Patient signature:_____

Date:_____

MEDICAL RECORDS RELEASE

I, _____, DOB _____, authorize the release of my medical records from:

Ophthalmologist/ Optometrist: _____ Phone (_____)_____

(First and Last Name) Fax (_____)_____

Primary Care Physician/ Internist: _____ Phone (_____)_____

(First and Last Name) Fax (_____)_____

Please send copies of my medical records to:

Dr. Elizabeth Holland, MD

612 Grove Road

Greenville, South Carolina 29605

Office# 864-312-3399

Fax# 864-312-3390

NOTE: PLEASE INCLUDE ANY TESTS INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT) AND VISUAL FIELDS

_____ _____

Signature Date