SOUTH COAST
EYE CARE CENTERS
A COMPREHENSIVE OPHTHALMOLOGY MEDICAL GROUP, INC.
Caring for your most precious resource

24022 Calle De La Plata, Suite 305
Laguna Hills, California 92653-3665

31852 Coast Highway, Suite 101
Laguna Beach, California 92651-6765

(949) 588-2020
www.southcoasteye.com

Dear Valued Patient,

Thank you for choosing, South Coast Eye Care Centers for your eye care needs.

In this packet you will find our practice registration forms, please complete these forms and bring them into our office the day of your appointment. ***Please also bring your insurance card(s) and a photo ID.***

Please bring a list of any medication and any eye-drops that you are currently using, along with your eyeglasses and or contact lenses. If you have a copy of your contact lens prescription or a box please bring this information.

Dilation of your eyes is necessary and will most likely be required for your examination. The effect of these dilation drops can last for 4 to 6 hours, we recommend that you not plan on driving immediately after your appointment. With this in mind please arrange for transportation and we apologize for the inconvenience but we are ***unable to validate parking***, if you choose to use the parking structure behind our Laguna Hills office.

Many insurance companies DO-NOT cover eye-examinations, we advise that prior to your appointment you discuss coverage benefits directly with your insurance provider.

South Coast Eye Care Centers, takes great pride in making your visit as successful and pleasant as possible.

Sincerely,

Tobi Foisy
Office Manager

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Confidential Patient Information

(Please complete BOTH sides)

PATIENT INFORMATION

Name _____
Last First Middle Initial

Social Security #_____ Date of Birth_____ Age_____ Sex_____ Marital Status _____

Home Address _____
Street City State Zip Code

Home Phone _____ Email Address _____ Driver's License #_____

Employer_____ Occupation_____ Work Phone_____

Nearest Relative (not living with you)_____ Relationship_____ Phone Number_____

RESPONSIBLE PARTY

Name _____ Social Security # _____

Home Address _____
Street City State Zip Code

Phone Number _____ Date of Birth_____

INSURANCE INFORMATION

Insurance Center _____

Circle One: HMO PPO POS MEDICARE WC OTHER:_____

Policy Holder's Name_____ Date of Birth _____ Social Security # _____

ID# _____ Group Number _____

Secondary Insurance Carrier _____

Policy Holder's Name _____ Date of Birth _____ Social Security # _____

ID# _____ Group Number _____

Do you have a Vision Plan? VSP EyeMed Safeguard OTHER:_____ ID#_____

ASSIGNMENT OF BENEFITS

I hereby authorize South Coast Eye Care Centers to furnish any information needed by any insurance carrier to process any claims for services rendered to the above named patient by South Coast Eye Care Centers. I assign any benefits payable by insurance carriers for those services to South Coast Eye Care Centers. I agree to be responsible for any amount not covered by insurance or for the full amount if the above named patient does not have insurance. If an account is sent to a collection agency, I agree to pay collection expenses as established by the collection agency.

Signature _____ Date _____

REFERRAL INFORMATION

How did you hear about us? _____

Primary Care Physician _____ Phone Number _____

MINOR CHILD

I hereby certify that I am legally responsible for the above names patient, and I authorize South Coast Eye Centers to examine and treat this patient.

Signature _____

South Coast Eye Care Centers Financial Policy

Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bills is considered part of your overall treatment. The following financial policies have been adopted for use at South Coast Eye Care Centers.

Acknowledging with your signature below, you understand and accept the following policies:

Required at Check-In:
Each time you check in for your appointment you will be required to:

- Verify Personal Contact Information
- Present Current Copy of Insurance Card
- Pay any Outstanding Account Balance
- Pay your Insurance Co pay

Administrative Fees and Fees for Non-Covered Services:

- A **$25 fee** will be charged for missing a complete eye exam without a 24hr notice
- Medical Records Release Charge - The medical records charge is $25
- Outstanding balances must be paid in full within 6 months if $500 or more, and 3 months if $499 and under.
- Collection Charges- Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency and reported to the credit bureau. Also you may be dismissed from the practice if your account is sent to collections.

HIPAA – South Coast Eye Care Centers is committed to providing a safe and confidential environment for all patients. Information will not be shared with others without your written permission. Our complete HIPAA privacy policy is available on our website, or you may ask for a printed copy when you are in our office.

I acknowledge receipt of a copy of this policy.

Print
Name_____Date_____

Patient Signature_____
(Signature of Parent/Guardian if patient is a minor)

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PATIENT'S ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have reviewed the South Coast Eye Care Centers Medical Information Privacy Notice prior to receiving services through South Coast Eye Care Centers.

_____

(Signature of Patient)

_____

(Print Name of Patient)

_____

Date

Please list members of your family, friends, or others with whom we may discuss your medical health information. If none, please so state.

1. _____
(Name) (Address) (Phone)

2. _____

3. _____

4. _____