retina of coastal carolina

PATIENT REGISTRATION

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth _____ **Social Security #** _____

Mailing Address: Street _____ Apt/Ste #_____

City _____ State _____ Zip _____

☐ **Permanent Address** ☐ **Seasonal Address**

Phone Numbers: Cell Phone _____ Home _____

☐ Check here if you **DO NOT** authorize Retina of Coastal Carolina to leave a message containing appointment information.

Email Address _____

☐ Check here if you **DO NOT** authorize Retina of Coastal Carolina to communicate with you via email.

Gender *(Please circle)*

Male / Female

Marital Status *(Please circle)*

Single / Married / Divorced / Separated / Widowed

Emergency Contact: Name _____ Number _____

Relationship to you _____

Primary Care Physician _____

City / State _____ Phone Number _____

MEDICAL INSURANCE

Primary Insurance Name _____ **Member ID** _____

☐ **I am the subscriber** ☐ **I am a dependent**

Secondary Insurance Name _____ **Member ID** _____

☐ **I am the subscriber** ☐ **I am a dependent**

GUARANTOR INFORMATION

☐ Check here if the **PATIENT** is financially responsible.

- If anyone **OTHER THAN THE PATIENT** is financially responsible, then please fill out the information below.

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth _____ **Social Security #** _____

Mailing Address: Street _____ Apt/Ste #_____

City _____ State _____ Zip _____

OFFICE POLICES

As a courtesy, Retina of Coastal Carolina (ROCC) will file claims with all contracted insurance plans. While we make every effort to verify your coverage, we cannot guarantee the accuracy of information provided by your insurance company. If incorrect or incomplete information results in a delay or denial of payment, you will be financially responsible for the charges.

PATIENT RESPONSIBILITIES:

- You will provide your current and correct medical insurance information at each visit, including insurance card(s) and a valid photo ID.
- You will notify us of any demographic changes such as address and phone number.
- You will notify us if you enter into a rehab facility or hospice arrangement.
- Understand your insurance coverage, including co-pays, deductibles, referrals, and authorization requirements.
- Pay your co-pay at the time of service.
- Pay any remaining balance after insurance processing, as reflected on your statement.
- If unable to pay in full, you will agree to enter into a payment plan with consecutive monthly payments.
- In the event of a claim denial, unrelated to billing errors, you may be asked to contact your insurance company to assist in denial resolution. Patient assumes full responsibility for payment if you fail to comply with the assistance request.

SELF PAY POLICY

We require a $200 upfront payment for all self-pay patients. Any remaining balance will be billed to you. If you are unable to pay in full, you will agree to enter into a payment plan with consecutive monthly payments. Depending on your income and employment status, you may qualify for assistance through the NC Division of Services for the Blind or Medicaid. Our financial counselors will provide you with their contact information. It is your responsibility to contact the appropriate source to determine eligibility. All payment arrangements are collected same-day, and payment plans must be followed as agreed.

LATE CANCELLATION / NO SHOW POLICY

We require at least 24 hours' notice to cancel or reschedule an appointment.

OUT OF NETWORK INSURANCE POLICY

ROCC does not file claims for non-contracted insurance plans. Patients with out-of-network insurance will be considered self-pay, and the self-pay policy will apply.

WORKERS COMPENSATION POLICY

Complete billing information is required for us to file a workers' compensation claim. If not provided, payment in full will be required at the time of service. We do not bill third parties such as attorneys or auto insurance carriers.

PATIENT ASSISTANCE PROGRAMS

Eligible patients may be enrolled in assistance programs to help cover the cost of injectable medications. You are responsible for any applicable co-pay at the time of service. Please note: These programs open and close at will. If the foundation runs out of funds, you will be responsible for any unpaid drug coinsurance.

USE OF DE-IDENTIFIED IMAGES FOR EDUCATION

I authorize Retina of Coastal Carolina to use my diagnostic imaging for educational purposes such as conferences, lectures, and training. I understand that all images will be de-identified and will not include any personally identifiable information. ☐ **Yes** ☐ **No**

ASSIGNMENT OF BENEFITS

I authorize payment of Medicare, Medicaid, and other insurance benefits directly to Retina of Coastal Carolina for services provided to me.

AGREEMENT TO ALL POLICIES

I acknowledge that I have reviewed and agree to the terms outlined above.

_____ _____

PRINTED NAME OF PATIENT **TODAY'S DATE**

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Retina of Coastal Carolina to release my medical, billing, and/or appointment information to:

NAME OF AUTHORIZED PERSON	RELATIONSHIP	INFORMATION TO RELEASE
_____	_____	☐ Medical ☐ Billing ☐ Appointment
_____	_____	☐ Medical ☐ Billing ☐ Appointment
_____	_____	☐ Medical ☐ Billing ☐ Appointment

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do so by written notification. I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

WRITTEN ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES

Effective Date: April 1, 2026

Our notice of Privacy Practices provides information about how we may use and disclose medical information about you.

We may use and disclose your health information for:

- **Treatment:** To provide and coordinate your care
- **Payment:** To bill and receive payment for services
- **Healthcare Operations:** To run our practice and improve care

We may also share your information when required by law or for public health and safety purposes.

You have the right to:

- Get a copy of your medical record
- Request corrections to your record
- Request limits on how we use or share your information
- Request confidential communications

We may update our notice at any time. The current version will be available in our office and upon request.

I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions of the Privacy Officer if I do not understand any information contained in the notice.

_____ _____

PRINTED NAME OF PATIENT **TODAY'S DATE**

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

For Office Use Only

We were unable to obtain the acknowledgment for the following reason:

☐ An emergency existed and a signature was not possible ☐ Patient refused to sign

☐ Unable to communicate with patient ☐ Other: _____

PAST MEDICAL HISTORY

Patient Name _____ **Today's Date** _____/_____/_____

Have you ever been diagnosed with: ☐ **NONE**

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder

Type: _____

- ☐ Blood Disorder
- ☐ Cancer

Type: _____

- ☐ Depression
- ☐ Diabetes - Type 1 or 2 - Year Diagnosed: _____

Provider who manages your diabetes:

Name: _____

- ☐ End Stage Renal Disease
- ☐ Enlarged Prostate
- ☐ GERD
- ☐ Heart Disease
- ☐ Hepatitis A / B
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Lung Disease

Type: _____

- ☐ Seizures
- ☐ Seasonal Allergies
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Other: _____

Past Ocular History: ☐ **NONE**

☐ Allergic Conjunctivitis	☐ **L**	☐ **R**
☐ Blepharitis	☐ **L**	☐ **R**
☐ Cataract	☐ **L**	☐ **R**
☐ Corneal Dystrophy	☐ **L**	☐ **R**
☐ Diabetic Retinopathy	☐ **L**	☐ **R**
☐ Dry Eyes	☐ **L**	☐ **R**
☐ Glaucoma	☐ **L**	☐ **R**
☐ Macular Degeneration	☐ **L**	☐ **R**
☐ Macular Pucker	☐ **L**	☐ **R**
☐ Narrow Angles	☐ **L**	☐ **R**
☐ Ocular Hypertension	☐ **L**	☐ **R**
☐ Ocular Migraine	☐ **L**	☐ **R**
☐ Posterior Vitreous Detachment	☐ **L**	☐ **R**
☐ Retinal Tear	☐ **L**	☐ **R**
☐ Retinal Detachment	☐ **L**	☐ **R**
☐ Strabismus	☐ **L**	☐ **R**
☐ Vitreous Floaters	☐ **L**	☐ **R**

Past Ocular Surgery: ☐ **NONE**

☐ Blepharoplasty	☐ **L**	☐ **R**
☐ Cataract Surgery	☐ **L**	☐ **R**
☐ Corneal Transplant	☐ **L**	☐ **R**
☐ Eye Muscle Surgery	☐ **L**	☐ **R**
☐ Intravitreal Injections	☐ **L**	☐ **R**
☐ LASIK / PRK	☐ **L**	☐ **R**
☐ Ptosis Repair	☐ **L**	☐ **R**
☐ Retinal Laser	☐ **L**	☐ **R**
☐ Scleral Buckle	☐ **L**	☐ **R**
☐ Trabeculectomy	☐ **L**	☐ **R**
☐ Tube Shunt	☐ **L**	☐ **R**
☐ Vitrectomy	☐ **L**	☐ **R**
☐ Yag Capsulotomy	☐ **L**	☐ **R**

MEDICATIONS

Please list all medications you are currently taking:

Medication	Dose	Medication	Dose

Pharmacy Contact Information:

Name: _____ Phone #: (_____)_____-_____

Address: _____

ALLERGIES

Please list all allergies and reactions if known: ☐ **NONE**

Allergy	Reaction	Allergy	Reaction

SURGICAL HISTORY

Please list all minor / major surgical procedures you have had: ☐ **NONE**

Surgical Procedure	Date	Surgical Procedure	Date

FAMILY HISTORY

Does anyone in your immediate family (blood relatives) have any of the following: ☐ **UNKNOWN**

Glaucoma	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Blindness	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Macular Degeneration	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Retinal Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Heart Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
High Cholesterol	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Kidney Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Lung Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Thyroid Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Autoimmune Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent
Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent

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INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to enlarge (dilate) the pupils to allow the ophthalmologist to better examine the inside of your eyes.

These drops may cause temporary blurred vision and light sensitivity. The effects can vary from person to person and may last several hours. Because your vision may be affected, driving after your appointment may be difficult. It is best if you make arrangements not to drive yourself.

In rare cases, dilating drops may trigger an adverse reaction, such as acute angle-closure glaucoma. This is uncommon and can be treated with prompt medical attention.

I authorize the physicians and/or their staff to administer dilating eye drops at each visit as needed. I understand these drops are necessary for proper diagnosis and treatment of my eye condition.

_____ _____

(Please print patient name) **TODAY'S DATE**

_____

Signature of Patient or Responsible Party