Dr. Tom MacMillan
Dr. Jeremy Anderson
Dr. Lindsay Wood
Dr. Alexis Mears

Spartanburg VISION

*Our **vision** is to protect **yours***

227 E. Blackstock Rd, Suite 200
Spartanburg, SC 29301
(864) 576-0564
www.spartanburgvision.com

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: _____ / _____ / _____ Age _____ Male / Female SS#: _____

Employer: _____ Occupation: _____ Email: _____

Name of Primary **Medical** Insurance Carrier: _____ ID #_____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

✦ *If you have **diabetes**, your exam will be billed to your **medical** insurance. Every diabetic exam requires dilation and a report will be sent to your medical provider. Please note that the specialist copay is typically between $30-$60*

Authorization for Release of Information

This form authorizes Spartanburg Vision to release protected information about the patient to the people listed below (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- ☐ Financial/Billing Information
- ☐ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

_____ _____
Name/Relationship to patient Phone

Access to your Glasses and Contact Lens Prescriptions

- In an effort to reduce paper waste, we request that you allow us to provide you with a digital copy of your prescriptions through our patient portal. Patient portal invitations are sent at the time of your first appointment with our office; however, you can request portal setup instructions at any time from our team.
- In addition to 24/7 access through your patient portal, we are always happy to provide you with a printed copy of your prescription or, if you prefer, we can also send it to you via email.

I agree to receive a digital copy of my prescription via the patient portal ☐ YES ☐ NO _____
(Please Initial)

Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for billing purposes. I hereby authorize payment from my insurance company to Spartanburg Vision.

We require that a retinal image is taken for every patient. The fee is $10 and is not covered by insurance.

X _____ _____ _____
Signature of Patient (legal guardian if minor) Print Name Date