CYNTHIA VOLPE, M.D.
STACY STORY, M.D.
CALEB STORY, M.D.

EYE PHYSICIANS & SURGEONS OF COLUMBIA

601 TAYLOR STREET
SUITE A
COLUMBIA, SC 29201
Phone (803) 256-7494
Fax (803) 799-0746

Dear Patient:

Welcome to Eye Physicians & Surgeons of Columbia. We are honored that you have chosen us as your health care eye provider and look forward to meeting you. Our goal is to provide the highest quality professional eye care for all of our patients in a timely and proficient manner.

In order for you to be seen as efficiently as possible, **we request that you arrive 15 minutes prior to your scheduled appointment time.** This will allow adequate time to ensure all required paperwork and insurance information is obtained and input into our system.

Please review, complete, and bring with you to your appointment the following items:

1. Patient Information Form
2. Consent / Authorization / Financial Policy Form
3. Patient History Form
4. Picture ID
5. Insurance Card(s)
6. Authorization Paperwork ***(if your insurance requires an authorization for coverage of the visit, please obtain this from your primary care physician)***

Payment is due at the time of service. This would include any co-pays, past due/bad debt balances, a self-pay status, services not covered by your insurance, refractions, etc.

Please remember that we have reserved this appointment time especially for you. If you are unable to keep your scheduled appointment time, please call our office at least 24- hours in advance at **(803) 256-7494** to cancel. We will be happy to reschedule you for another date and time.

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PATIENT INFORMATION

Patient Name: _____ Name Preferred: _____
Last First Middle

DOB: _____ SSN: _____ Sex: _____ Race: _____

Address: _____
Street City State Zip

Email: _____ Cell Phone: _____ Other Phone: _____

Preferred Method of Contact for Appointment Reminders: ☐ Cell Phone/Text ☐ Email ☐ Other Phone/Text

Emergency Contact Name: _____ Phone Number: _____

RESPONSIBLE PARTY

Name of Insured: _____ DOB: _____ Relationship: _____

Address: _____ SSN: _____ Phone: _____

INSURANCE INFORMATION

Medical Insurance: _____ Vision Insurance: _____

HIPAA RELEASE FORM – VERBAL ONLY

I authorize the **verbal release** of information including the diagnosis, treatment, testing and examination findings, and claims information from Eye Physicians & Surgeons of Columbia to the following person(s):

NAME	RELATIONSHIP

***This Release of Information will remain in effect until terminated by me in writing.**

Date: _____ Signature: _____

CONSENT FOR TREATMENT

I hereby agree and give consent to the treating physician and employees of Eye Physicians & Surgeons of Columbia and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

AUTHORIZATION / RELEASE

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to Eye Physicians & Surgeons of Columbia. I hereby assign to Eye Physicians & Surgeons of Columbia all payments for treatment services. *I **understand and agree that** I **am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.***

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and understand my rights contained in the notice. I hereby authorize the release of medical information to Medicare, Medicaid and/or other insurance plans or payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

FINANCIAL POLICY

I have read and understand the FINANCIAL POLICY of Eye Physicians & Surgeons of Columbia and I agree to abide by its terms. I understand that I am financially responsible for all charges not covered by insurance and agree that such terms may be amended from time-to-time by the practice.

My signature below represents my acceptance of the Consent for Treatment, Authorization/Release, and Financial Policy statements above.

Patient's/Parent's/Representative's Signature

Date

Printed Patient's or Representative's Name

Relationship to Patient

EPSC PATIENT HISTORY

Name _____ Date of birth _____

Current primary care provider _____ Practice _____

Check if any of the following apply to you:

☐ Blurred vision	☐ Loss of vision	☐ Double vision	☐ Dry eyes	☐ Tearing
☐ Floaters	☐ Flashes	☐ Droopy lids	☐ Crossed eyes	☐ Eye pain
☐ Cataracts	☐ Glaucoma	☐ Retinal disease	☐ Macular degeneration	

Prior eye surgeries / lasers / procedures (including dates) _____

_____

Check and explain if you have symptoms or diagnoses in any of the following categories:

☐ Heart (chest pain, arrhythmia, stents/bypass) _____

☐ Lungs (trouble breathing, asthma, COPD) _____

☐ Gastrointestinal (nausea, food sensitivities, IBS) _____

☐ Cancer (past/present) _____

☐ Genitourinary (kidney, bladder, prostate) _____

☐ Neurologic (neuropathy, dementia, Parkinson's) _____

☐ Psychiatric (depression, anxiety) _____

☐ Dermatologic (eczema, rosacea) _____

☐ Allergies (foods, allergens) _____

☐ Musculoskeletal (arthritis, joint replacement) _____

☐ Autoimmune (lupus, rheumatoid arthritis) _____

☐ Immune disorder (HIV, immunosuppression) _____

☐ Hematologic (blood or lymph disorders) _____

☐ Endocrine (diabetes, thyroid issues) _____

☐ Hypertension/Elevated Cholesterol _____

☐ Other _____

Family History – please indicate if any family members have had the following, and the relationship to you:

☐ Glaucoma _____ ☐ Macular degeneration _____

☐ Retinal diseases (such as retinitis pigmentosa, retinal detachment) _____

☐ Blindness _____ ☐ Other (please explain) _____

Social History

Do you smoke? ☐ Y / ☐ N Do you drink alcohol? ☐ Y / ☐ N Are you pregnant or nursing? ☐ Y / ☐ N

MEDICATION ALLERGIES: _____

Please bring a list of your medications with you to your appointment, and please bring any eye drops with you.

Pharmacy: _____

Occupation / interests (golf, reading, sewing, computer, etc) _____